Commission on the
Future of Health Care
in Canada

Commission sur
l'avenir des soins de santé
au Canada

Report on Citizens' Dialogue on the Future of Health Care in Canada

Prepared for the
Commission on the Future of Health Care in Canada

By Judith Maxwell, Karen Jackson, Barbara Legowski
Canadian Policy Research Networks

Steven Rosell and Daniel Yankelovich
Viewpoint Learning Inc.

In collaboration with
Pierre-Gerlier Forest and Larissa Lozowchuk
Commission on the Future of Health Care in Canada

JUNE 2002

102-06240/

Report on
Citizens' Dialogue
on the Future of Health Care in Canada

Cat: CP32-77/2002E
ISBN :0-662-32402-1

Contents

Executive Summary v

Acknowledgments xiii

I What Is a Citizen's Dialogue? 1
The Purposes 1
The Approach 1
The Methodology 3
The Dialogue on Health Care 5
Who Were the Citizens 7

II The Challenges and the Choices for Citizens 9
The Challenges 9
The Scenarios 13

III Canadians' Health Care Values 15
The Core Values in 2002 16
The Canadian Model – 2002 23

IV The Morning: Citizens' Vision of a Desirable Future for Canada's Health Care System 27
Initial Views of the Four Scenarios 27
Beginning the Dialogue 28
The Health Care System Citizens Want 30

V The Afternoon: Making Choices and Trade-offs 35
Reorganizing Service Delivery 36
Increased Funding… Make It Public 40
Stronger Accountability and Transparency 46
Citizens' Judgment on Health Reform 53

VI Confirming the Choices 55
Final Views of the Four Scenarios 55
The Follow-Up Survey 58

VII Conclusions 65
Citizens' Conclusions 65
Policy Conclusions 66
Concluding Comments 71

Appendices

1 – Basic Steps in a ChoiceWork Project 73
2 – Dialogue Dates and Places 75
3 – Facilitators' Prompts 77
4 – Quantitative Findings 79
5 – Workbook 81

Notes 121

Executive Summary

Introduction

Public opinion polls show that Canadians are deeply attached to their health care system.[1] Polls consistently show that Canadians want and expect quick access, high quality, and universal coverage. But they also suggest that Canadians have not yet come to terms with how best to pay for the rising costs of these services, nor how best to access them in a society that has changed since Medicare was first established.

The Commission on the Future of Health Care in Canada decided to go beyond the kind of information that polls provide. They wanted to learn how Canadians reconcile the difficult trade-offs inherent in sustaining the health care system in the 21st century. The Commission was searching for reliable information on citizens' values and their preferred choices when they are asked to make difficult trade-offs. In Commissioner Romanow's words to the dialogue participants in this project:

> There are no right or wrong answers here. What I want… is a better sense of what you collectively value as important and believe to be the right path to take and why. I want to understand what aspects of the solutions you prefer – and do not prefer – in order to better focus my Commission's final recommendations.

To do this, the Commission formed a partnership with the Canadian Policy Research Networks and Viewpoint Learning to organize a Citizens' Dialogue using "ChoiceWork Dialogue" methodology.[2]

The Process

The dialogue involved 12 sessions held across the country with about 40 citizens at each. Participants were randomly selected in a manner designed to provide a representative cross-section of the Canadian population. When contacted, people quickly agreed to commit a full day on a weekend and in some cases to travel long distances. Almost all of those who accepted showed up at the appointed time and place, despite the usual travel hazards of the Canadian winter. They were informed and thoughtful when they arrived and it was remarkable how quickly they absorbed even more information, learning from each other and the dialogue materials.

Participants were asked to reflect upon four scenarios for reforming the health care system. Each one has at its core a reform perspective under active discussion in Canada today.

---

[1] Mendelsohn, Matthew, "Canadians' Thoughts on Their Health Care System: Preserving the Canadian Model Through Innovation," prepared for the Commission on the Future of Health Care in Canada, Saskatoon, November 2001.

[2] ChoiceWork Dialogue is a methodology developed by Viewpoint Learning. It is described more fully in Chapter I.

- Scenario 1 explores *more public investment* in doctors, nurses, and equipment, either through tax increases or by reallocating funds from other government programs.
- Scenario 2 involves a form of private payment for health care. Entitled *share the costs and responsibilities,* it proposes a system of user copayments for health services.
- Scenario 3 offers a more radical restructuring of health care to create a parallel private system. *Increase private choice* enables people to access private providers, paying from personal resources or private insurance.
- Scenario 4 proposes a major internal restructuring to *reorganize service delivery.* Each Canadian would sign up with a health care provider network, which would include doctors, nurses, and other professionals working as a team.

Citizens' first task was to use the information in these scenarios to create their own vision of the health care system they would like to see in 10 years. They then spent almost five hours working through difficult trade-offs and choices to realize their vision. The vision they developed and the choices and trade-offs they made to realize that vision were remarkably consistent across the 12 groups. These have since been further confirmed through a follow-up telephone survey with a larger sample of Canadians.

Past attempts to engage citizens in health care reform have been stymied by their resistance to making the tough trade-offs. The National Forum on Health in 1996 found, for example, that "participants were ingenious at avoiding the hard issues." The full day of discussion and the ChoiceWork methodology did not allow citizens to avoid those choices. Instead, with time, information, and an opportunity to work through the difficult trade-offs with each other, citizens were able to express their values and find acceptable choices and alternatives based upon those values.

This report presents two kinds of analysis: quantitative analysis of the pre- and post-dialogue questionnaires and the national poll, and qualitative analysis of the videotapes and observers' notes of each session.

Key Findings

Canadians are passionate about health care and very concerned about its future. They want to keep the core principles of the Medicare model that accord with their strongly held values of universality, equal access, solidarity, and fairness. But they also state very clearly that the current uses of health care resources do not correspond well to their values of efficiency and accountability. Citizens wish not only to preserve and protect the best of the Medicare system built over recent decades but also to update it and to make it sustainable for the future. To achieve that, they are ready to change their own behaviour, and they expect the providers, managers and governments to do the same. When given a chance to work through the issues, citizens are far more open to change in the delivery of health care services than most politicians imagine.

When they weigh the pros and cons of all four scenarios and discuss them with their fellow citizens, they forge a consensus that draws upon three of the four scenarios. But they go beyond the scenarios provided. They sift through possibilities, rejecting some and accepting and refining others to come to judgment on a set of acceptable parameters for the future.

While the exact sequence of steps varies somewhat from group to group, citizens weave their logic for reform as follows:

- At first many citizens hope that the system can be "fixed" simply by eliminating waste and improving the efficiency of management and service delivery, and perhaps reallocating funds from other programs. But that hope begins to fade as they share experiences with each other, and work through the issues and the current and projected costs of health care.
- The focus then shifts to renewing the system through reforms that are consistent with the values of access based on need, fairness and efficiency. Citizens see the potential in having a team of medical professionals (doctors, nurses, pharmacists, and others) to provide more coordinated primary care, supported by a central information system. They also are very attracted by the idea that such a team would not only provide more coordinated, cost-effective care, but also would have greater incentive to focus on wellness, prevention and patient education. To make it work, they understand, will require changes in the behaviour of citizens, providers and governments.
- In working through the changes they are prepared to make in order to make these reforms work, citizens agree for example to sign up with a team of professionals for at least one year, see a nurse for routine care, and make greater use of new technologies including 24-hour phone lines. And, notwithstanding their real concerns about privacy, they agree to make personal medical information more available through a "smart card" – an electronic health card – to help ensure that care is better coordinated and to uncover any abuse of the system. They conclude that the benefits of the smart card outweigh the (privacy) costs. Citizens also pledge to assume greater responsibility for their own health, through diet, exercise and more healthy living.
- Even with these changes, participants come to realize that more funding will be required to sustain the health care system they value. They struggle with where the money should come from.
- They choose not to turn to greater private investment through a parallel private system as a means to inject more money into health care. While they explore the idea, most underline that the only way such a scenario would be acceptable is if it did not harm the public system. By the end of the dialogue, this scenario is rejected by participants who conclude it cannot meet that test, and would drain valuable resources away from the public system.
- They also wrestle with the idea of copayments. They recognize that some revenue would be generated and many believe inappropriate use of the system would be deterred. But participants are very uncomfortable with charging user fees for basic services, believing it will discourage those who are less well off from seeking needed care. This concern remains even when a subsidy for low-income citizens is proposed. Most conclude that a better way to reduce misuse of the system is through the use of information systems and the smart card. Through the electronic health cards, they expect individual use to be monitored so that corrective actions can be taken when

they are found to be misusing the system. Many also want to receive an annual print-out reporting on their use of the system and the associated costs. In the end, the door is left open to paying user fees for extra services only (for example, a second opinion provided by a physician outside of a rostered system).

- In the end participants turn to public funding and, reluctantly, to tax increases rather than to cuts in current programming. At first the hope is that transfers of funds from other programs can be used, but as citizens work through the possibilities, and one by one eliminate the candidates (such as education and social programs), they are left with tax increases as the only viable choice.

- At the same time citizens place very stringent conditions on their support for any tax increase. They insist on stronger accountability from providers and governments as well as from users. The message is "we are spending $100 billion already; we have to get our act together." Citizens demand greater transparency about where the money goes and what actions add value. Distrust of the way in which the health care system is being managed was palpable in every dialogue. Concerns about accountability, transparency and value for money echoed throughout each session. Citizens across the country were clear and remarkably consistent in the improvements they wanted to see in the management of the system:

  - *Greater transparency.* Citizens want to know where the money is going. They want to see regular reports for their region and jurisdiction that show how the system is being used and how the money is spent.
  - *Earmark taxes for health care.* To further increase transparency, citizens want to be sure that any additional taxes for health care will be spent on health care.
  - *Create an auditor general for health.* Citizens want documentation of value for money, and of how their jurisdiction is doing in relation to its past performance and to other jurisdictions. They believe that this information should come from an independent agency, such as an auditor general for health with an overall purview of the state of Medicare.
  - *Greater efficiency and co-operation within and among governments.* Citizens are:
    - fed up with federal-provincial disputes, which they see as adding cost and delaying decisions without improving the services they receive. They want to know more clearly who is responsible for what so that the responsible party can be held to account.
    - aware of the connection between health and other governmental responsibilities such as the environment, social programs, and housing. They want joint interdepartmental strategies to address the determinants of health.
    - demanding greater efficiency generally. For example, they believe that when regional institutions are created, provincial ministries should be reduced in size, and that politicians and ministries should not second-guess decisions at the regional and local levels. Overall, they want to see duplication reduced, and responsibilities and accountabilities spelled out more clearly.
  - *Establish a national ombudsman.* Some citizens would like to have a national patient ombudsman, acting as an advocate on their behalf.

By the end of the day, citizens' responses to the scenarios reveal a much greater openness to change than there had been eight hours previously. They adjusted their "coming in" stereotypes and came to recognize merits and possibilities in approaches they did not originally like. By the end of the dialogues, an extraordinary 8 out of 10 participants (79 percent) were in favour of reorganizing service delivery. By contrast, despite considerable discussion, almost half (47 percent) remained firmly opposed to increasing private choice through a parallel private system, while 39 percent expressed support.

The Canadian Model – 2002

Health Care Values

Universality... everyone is included.
Equity... individual access is based on need.
Solidarity... we are in this together – we all contribute to health care and take from it when we need to.
Fairness... we contribute based on means.
Quality... care is timely and responsive.
Wellness... prevention is key.
Efficiency... sound management and responsible behaviour ensure value for money.
Accountability... everyone is accountable for how they use or affect the system; decision making and spending are transparent.

Citizens gain a greater sense of ownership of the health care system during the dialogues. They go beyond their roles as users or consumers, to see themselves as owners, investors, and stakeholders. Their final judgment, at the end of the day, expresses the essence of a revised health care contract among citizens, and between citizens and the health care system – governments, managers, and providers.

The health care contract imagined by Canadians in 2002 is different from the past. In the mid-1960s, when Medicare was introduced, a key goal was to protect citizens from personal bankruptcy. In 1984, when the *Canada Health Act* was introduced, the main focus was on buttressing universality and equal access. Now, in 2002, citizens who are given the opportunity to reflect deeply on the challenges we face are ready for change in order to preserve the essence of Medicare while adapting it to new realities. They believe the system as it now functions is not sustainable. Once they work through the choices and trade-offs, most Canadians conclude that they are not willing to pay more for the status quo, but they are willing to pay more if certain conditions are met.

The most important shift is the introduction of explicit economic and political values into the contract. Efficiency and accountability were part of the values identified by the National Forum on Health in 1996, but they were not articulated in health care choices. They are now, and they bring a harder edge to the logic of reform.

Thus **citizens** speak openly about their rights and responsibilities as citizens. They believe they have a right to equal access and to efficient and responsive health care. But they also establish a list of personal responsibilities for which they are to be held accountable – to take care of their own health, to use the health care system judiciously, to adapt the way they access the system to permit efficiency gains, and to pay their fair share of the tax cost.

In summary, the unique contribution of the Citizens' Dialogue has been to enable citizens to link new and old values into a revised health care contract, updated to 2002. Then in a new and powerful way, those values have been applied to the fundamental questions of health care reform.

Citizens are trying to build a bridge to a better, financially sustainable health care system, based on the Medicare model. They used their core values and principles to give governments permission to make significant reforms. They also set some very challenging conditions for citizen consent.

The new health care contract can be paraphrased as follows:

> *We place a high value on equal access and universal coverage. We see health care as a public resource for all citizens. Therefore, we will help to create a sustainable health care system, on condition that governments and providers commit to three significant changes: more efficient management and service delivery, more coordinated and patient-centred care, and greater transparency and accountability in how they spend health care dollars.*
>
> *With progress on these commitments, we are prepared to change our own behaviour to promote wellness, make certain sacrifices in the way we access the system, and to pay more. In paying more, our first choice is to pay through taxes earmarked for health care, so that basic services are financed through more public investment. As a backup, we will accept copayments or user fees for a limited number of additional services. On balance, we do not support the creation of a parallel private system.*

Policy Implications

There are a number of important additional implications for policymakers in these results:

- First, there is a wide gap in perception between the public and health care elite in Canada. The elite has spent 10 years reforming the system to make it more efficient. But what citizens seem to be saying is that this restructuring has not improved the day to day care which they experience on a regular basis – they are paying more and getting less. Nor has it raised their confidence that the system is now more sustainable.
- There are opportunities for health care reform that did not exist in the past. Citizens are ready to adopt new ways of interacting with service providers, which policymakers have usually assumed would be resisted. In addition, they see information and communication technologies as a double win – increasing efficiency

and making care more accessible. On the issue of wellness, prevention, and promotion, citizens were remarkably consistent from coast to coast. Observers wondered if Canada is on the cusp of a major societal shift from a disease-based to a wellness-based way of thinking. Citizens have a well-rounded view of wellness. It is a personal responsibility, a result of good fortune, and a state responsibility. The state responsibility cuts across nearly every ministry of government including industry, environment, housing, transport, natural resources, agriculture, education, and more. Citizens feel vulnerable to health risks in the air, water, food and drugs that they consume. The combination of their vulnerability and their desire to live a healthy life creates a remarkable opening for public policy, across the spectrum of government programming.

- Finally, but perhaps most important, is the willingness and capacity of Canadian citizens to take up the opportunity to engage in a dialogue of this sort. What does this will and capacity to engage mean for the way that Canada practices democracy?

  Engagement is needed when public policy is at a key turning point. This usually occurs when a society is reassessing its options, setting priorities, mapping the boundaries of where major change is possible. Engagement helps to clarify how deeply held values are evolving with changing circumstances. The legitimacy and sustainability of our most important public policies depend on how well they reflect those underlying (and evolving) Canadian values. But engagement only works when policymakers are ready to invest in learning and listening, when they are ready to open up a discussion on the big conflicted choices and trade-offs, and when they place a high value on the process of public learning.

This dialogue has given citizens an opportunity to update their fundamental values for health care. Their lives have changed profoundly since the 1960s, and their values have evolved as a result of that experience.

This restatement of values has major implications for public policy. It should lead to changes in the principles that govern the health care system and to more responsible and responsive behaviour on the part of governments, providers, and managers.

Citizens have had their say on health care reform in the winter of 2002. They said it well and with passion. It was a privilege to witness their dialogue.

Acknowledgments

The authors wish to express their appreciation to the large number of people who assisted the team in conducting this Citizens' Dialogue and preparing the report. The staff of the Commission on the Future of Health Care in Canada provided constant guidance and support throughout the project. Steven Rosell and Suzanne Taschereau were the lead facilitators, assisted by Pamela Pritchard and Rod Brazier. A number of researchers, practitioners, and experts on the health care system across Canada provided advice on the development of the scenarios. Sandra Zagon provided backup to the Canadian Policy Research Networks team and helped with the translation process. Leigh McGowan provided logistical and administrative support, and Prime Strategies arranged all the on-site logistics for the dialogue sessions and the participants' travel and accommodations. Ekos Research Associates recruited the participants, analyzed the questionnaire results, and conducted the follow-up poll. Sylvia Burns did the line edit.

And last, but not least, we must recognize the 489 citizens who responded with such enthusiasm to this opportunity to make a contribution to the future of health care in Canada.

We thank you all, and take full responsibility for any errors that crept into the report.

I What Is a Citizens' Dialogue?

In the spring of 2001, the Prime Minister asked the Commission on the Future of Health Care in Canada to inquire into and undertake a dialogue with Canadians on the future of Canada's public health care system. From the beginning of his mandate, Commissioner Roy Romanow spoke of one of his challenges as facilitating "collective learning and responsible public judgment among Canadian citizens."

The Purposes

There were two purposes to the Citizens' Dialogue Project. It was designed to contribute in however modest a way to a process of collective learning. Even more important, it was to help gain insight into citizens' values and their preferred choices when they are asked to make difficult trade-offs.

The participants of the 12 dialogue sessions gave ample testimony to the learning that occurred throughout the dialogue sessions. They spoke of how they had acquired a better understanding of the complexity of the issues, of how they were heartened to discover the breadth of common ground among them and of how they now appreciated far better the difficult choices and trade-offs to be confronted. Participants and observers commented repeatedly on the high level of conversation. Thoughtful and informed when they arrived, some citizens had strong opinions while others had open minds. It was remarkable how they quickly absorbed complicated information, learning from each other and the workbook provided, and applied their new knowledge to make difficult trade-offs.

As this report will reveal, Canadians share a set of core values about health care in Canada. These values were expressed and re-expressed by participants in ways that resonated widely with their fellow citizens. As these values were revealed, citizens used them to sift through possibilities, rejecting some and accepting and refining others to come to judgment on a set of acceptable parameters for the health care system of the future.

What citizens have to offer (indeed, what they must provide to health care reform) is the values basis upon which to build acceptable policies for the future. It is Canadians as a whole – not decision makers or experts alone – who must contribute the core values that should guide reform. The values, in turn, should be used to define what are acceptable possibilities and alternatives, and what are not.

The Approach

Royal Commissions, task forces, commissions of inquiry and legislative committees have repeatedly struggled with the best ways to gather public views and opinions. The traditional approaches such as public hearings and town hall meetings can serve important purposes in public consultation strategies, but they do not create the ambience where average citizens can present their views and participate actively in the public debate.

Similarly, public opinion polls and randomly selected focus groups have their purposes. They can provide snapshots of public opinion as it exists at a given point. The information to be gleaned from such techniques, however, can rarely be used to anticipate the directions public preferences are likely to take in future, nor do they reveal the factors and considerations that will prompt people to change their opinions.

For the past decade, Canadians have been experimenting with ways to give citizens a greater voice in public policy, especially in health policy.[1] For example, researchers have evaluated the efforts of regional health authorities and district health councils to engage the public when difficult restructuring decisions were under consideration.[2] Generally speaking, these efforts have focused on local issues, and most participants have been self-selected.

All recent health care inquiries in Canada (led by Messrs. Clair in Quebec, Fyke in Saskatchewan, and Mazankowski in Alberta, and by Senator Michael Kirby) have invested in some form of consultation with stakeholders and the public. But the difficulty with the traditional forms of consultation is that they do not enable citizens to think through the fundamental trade-offs, and to find ways to reconcile conflicting values.

The National Forum on Health, in 1996, did depart from traditional practices. It explicitly set out to learn Canadians' core values in relation to health care by having focus groups discuss a series of scenarios that presented discrete issues and personal situations. However, the Forum did not find a method that enabled citizens to make the trade-offs needed to come to terms with difficult reform choices.

The Commission on the Future of Health Care in Canada is the first commission of inquiry to sponsor a research project designed to probe deeply not only Canadians' current views, but also how those views evolve as citizens work through difficult trade-offs in dialogue with each other and try to reconcile those views with their deeper values. The ChoiceWork Dialogue methodology used to accomplish these objectives is described below. In addition, the Commission is undertaking an ambitious program of public consultations with experts, providers, managers, governments and citizen groups.

The project required a large investment on the part of citizens, the Commission, a team of researchers and support services. But, as documented here, it has produced a qualitatively different and much richer set of insights than can be expected from other more traditional techniques of consultation.

Citizens understood and accepted fully that they were not being asked to decide. Rather they were being given an opportunity to offer decision makers a deeper understanding of their views, where they are well defined and fixed, and, where they are flexible and open to change.

The Methodology

The partners in this project, the Canadian Policy Research Networks (CPRN) and Viewpoint Learning, adapted the latter's ChoiceWork Dialogue methodology and applied it in the Citizens' Dialogue. The Commission staff contributed unique experience with public participation, participated actively in the development of the scenarios, and provided extensive notes and comments from their observations of the dialogue sessions.

The ChoiceWork methodology is particularly valuable on issues at early stages of development, or on familiar issues where changed circumstances create new challenges that have to be recognized and addressed (such as health care). Under these conditions people's top-of-mind opinions are highly unstable and misleading. The challenge is to identify how those opinions are likely to evolve as people learn.

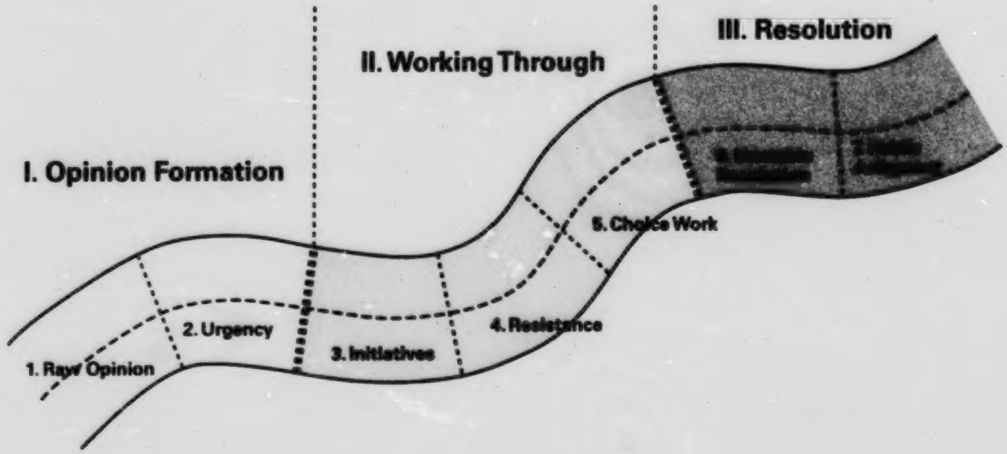
The methodology offers the missing link in the opinion-formation process. The conventional public education model holds that public opinion is formed through a simple two-stage process: information leads to public judgment. However, on complex issues such as health care, public judgment evolves through three stages, not two. The middle stage of "working through" conflicting values and hard choices intervenes between opinion formation and resolution.

The methodology is based on the research of Daniel Yankelovich (Chairman of Viewpoint Learning) into the stages through which public opinion develops, from initial raw opinion to more considered public judgment, and is illustrated in Figure 1.[3]

Figure 1

"Journey" of Public Opinion

From Raw Opinion to Public Judgment



Yankelovich's half-century of empirical research[4] into what constitutes thoughtful and responsible public judgment shows that people's views on issues form and change over time, evolving in several distinct stages. The media and events play a major role in the first stage of raising public awareness of issues.

The second stage is initiated when leaders articulate options for dealing with an issue. This is when issue resolution most often stalls, especially if hard choices and painful trade-offs are involved. Wishful thinking is a powerful force and, unless people have an incentive to confront reality, holding off from making difficult decisions is an all too human tendency. Unless people have an incentive to "work through" an issue, the issue does not progress toward resolution. Without some impetus to move it forward, it can remain unresolved for years.

Sooner or later, once people confront reality and work their way through this difficult stage, governments (and private organizations) can play a key role in advancing resolution – the third stage – through different forms of policymaking (including legislation and regulation).

This three-stage journey from raw opinion to public judgment is one that centrally involves values and emotions as well as deliberative thought. It requires not only a process of thinking through (deliberation) but also a psychological process of working through deeper values and emotional responses.

ChoiceWork Dialogues encourage that process of learning and working through, which involves at least four steps:

1. Taking in the facts;
2. Connecting the dots;
3. Facing up to conflicting values; and
4. Shifting from an individual to a broader community-based point of view.

Citizens are presented with a range of *scenarios* on a given issue. Each scenario presents a distinct direction for public policy, with the pros and cons of each. They are then invited to participate in serious dialogue with one another on these choices. In this kind of dialogue people's feelings and values come into play as well as their intellect. It is the emotional engagement that allows people to find common ground. In the real world, people shape their opinions and judgments by interacting with one another rather than by deliberation and analysis alone. This is the way public opinion actually evolves – by people engaging with the views of those with whom they can identify: including friends, family, neighbours, co-workers, other citizens, and those with whom they can identify among leaders and in the media.

The ChoiceWork Dialogue methodology is designed to help people move beyond their initial impulse to avoid hard choices and disagreeable realities. It encourages them to work through their internal resistances and come to grips with difficult issues as they engage with one another. It allows them to interact and to change their views as they work together to reconcile those views with their deeper values. One advantage of the technique is that it offers profound insight into how people really feel, what matters most to them, what trade-offs they will or will not accept, and how that is likely to evolve.[5]

The Dialogue on Health Care

Twelve day-long dialogue sessions were held across Canada, each with an average of 40 citizens who had been randomly selected to be representative of the wider population. The sessions occurred between late January and early March 2002 on either a Saturday or Sunday. There were three sessions held in each of four regions – Atlantic, Quebec, Ontario and the West. Three were conducted in French, nine in English. Because the health care system and the fiscal situation vary significantly from one province to another, citizens often spoke about recent local events. But despite the different contexts, the commonalities in the views and values expressed, and in the way citizens worked through the issues across the 12 sessions, are striking.

Following a standard format, the dialogues were facilitated by one of two teams of professional facilitators.

Participants were given four scenarios to use as their starting point. Each scenario has at its core a direction for health care reform currently under active discussion. The scenarios were described for the participants in a workbook that they received as they arrived for the dialogue sessions. It included background information, the basic elements, and key arguments for and against each scenario. The participants used this workbook in both small groups and plenary sessions, first to define their preferred visions of a future health care system and then to explore the actions and trade-offs they were prepared to take or to support in order to achieve that vision.

The day began with citizens completing a questionnaire on their initial perspectives on the scenarios and it ended with them repeating the questionnaire to measure how their views had changed in the course of the day. The sessions were videotaped and those videotapes have significantly informed the writing of this report. In addition, observers attended all sessions and took notes of what citizens said. The findings presented here combine qualitative analysis of the videotapes and the reports of the observers, with quantitative analysis of the questionnaires.

The results of the dialogue were further verified through a post-dialogue poll of 1,600 Canadians. While a poll cannot replicate the working through and learning that occurs during a day-long dialogue, the poll results confirm the similarity of the views of dialogue participants with those of the wider population. That, and the remarkable consistency in the results of the 12 dialogue sessions across the country, suggests that the findings in this report can be generalized to the wider population.

Finally, simplified versions of the scenarios used in the Dialogue Project have been used in the Commission's consultation workbook available on its Web site and in hard copy. Canadians have been invited to register their views and, at the time of writing this report, almost 10,000 had done so. The on-line workbook differs from the Dialogue in three important ways. First, the respondents are a self-selected group rather than a representative sample of the population, making it impossible to generalize findings to the wider population. Second, the on-line version of the workbook is designed to be completed in about 15 minutes. So on-line respondents have not had the opportunity to engage in the systematic working-through and learning process that occurs during a day-long dialogue. Finally, the workbook and its scenarios were just the starting point for the dialogue sessions, and participants were able to add their own ideas in the course of the dialogue in a way that those responding to the web site could not.

Who Were the Citizens

The 489 Canadians who participated in the day-long dialogues included a representative cross-section of the population. There were healthy Canadians, there were those who had suffered through serious bouts of illness or injury, those living with chronic conditions and disabilities, and others who were caring for sick or failing family members. There were smokers. There were those who were physically fit and those who were not. There were those who had been born and lived their entire lives in Canada and others who were newcomers from other parts of the world. One-quarter participated in French, the remainder in English. Health care professionals and managers were screened out, as were those who would not have been able to listen and express themselves in either English or French.

While the dialogues were held in major centres,[6] people travelled from surrounding areas and rural areas further afield. Two dialogue sessions were held in Halifax with some participants travelling from the other three Atlantic provinces to participate in each. Participants from both Saskatchewan and Manitoba attended the dialogue session in Regina.

When contacted, people were very responsive and enthusiastic. The task of recruitment was complicated by the enthusiasm, not by apathy or unwillingness to commit to attend. Very few who said they would attend did not come.

Based on their answers to a series of recruitment questions, the participants' attitudes were generally representative of the population as a whole. This was further verified in the poll conducted following the dialogues.

II The Challenges and the Choices for Citizens

To fully understand the results of the Citizens' Dialogue it is necessary to know the starting point. This chapter describes the information given to citizens in the workbook, as well as in a set of wall charts and in the briefing by the facilitators. Excerpts from the facilitators' presentations and the workbook are presented here and a footnoted version of the entire workbook, citing data sources, is reproduced in Appendix 5. The footnotes were removed in the version of the workbook used by citizens.

The challenge for the project team was condensing a vast amount of information, simplifying it so that citizens with varied literacy skills could absorb the ideas, and providing a balanced perspective on the pros and cons of the policy directions, some of which are highly controversial.

The Challenges

The project team chose to present three key issues to citizens as symptomatic of the critical challenges facing the health care system: rising costs, growing dissatisfaction among the public with the quality of care, and the uneven coverage provided by the public system. Citizens absorbed the information and used the workbook extensively. But they went well beyond the material presented. They brought their own interpretations of these three challenges and added their own experiences and concerns. Excerpts from the workbook and wall charts follow.

"The conditions under which Medicare[7] started in the 1960s were very different than they are now and will be in the future. The population was smaller and younger. The number and cost of services that were regarded as medically necessary were less. With an aging population and an explosion of technology that permits the health care system to offer many more services, Medicare has begun to show stresses and strains over time. Today that stress shows up in the form of rising costs, dissatisfaction and questions about what new health services should be covered.

Adjusting for inflation and population growth, between 2000 and 2020 total health care spending in Canada, both public and private, is predicted to grow by 56% – from $2,626 per person to over $4,100 annually. Total spending will rise from $81 billion to $147."[8]

II The Challenges and the Choices for Citizens

To fully understand the results of the Citizens' Dialogue it is necessary to know the starting point. This chapter describes the information given to citizens in the workbook, as well as in a set of wall charts and in the briefing by the facilitators. Excerpts from the facilitators' presentations and the workbook are presented here and a footnoted version of the entire workbook, citing data sources, is reproduced in Appendix 5. The footnotes were removed in the version of the workbook used by citizens.

The challenge for the project team was condensing a vast amount of information, simplifying it so that citizens with varied literacy skills could absorb the ideas, and providing a balanced perspective on the pros and cons of the policy directions, some of which are highly controversial.

The Challenges

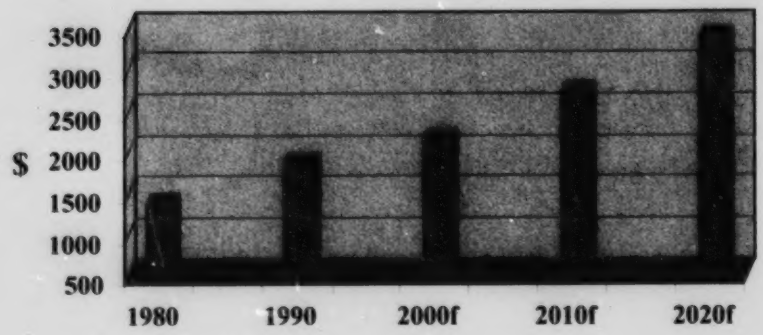
The project team chose to present three key issues to citizens as symptomatic of the critical challenges facing the health care system: rising costs, growing dissatisfaction among the public with the quality of care, and the uneven coverage provided by the public system. Citizens absorbed the information and used the workbook extensively. But they went well beyond the material presented. They brought their own interpretations of these three challenges and added their own experiences and concerns. Excerpts from the workbook and wall charts follow.

"The conditions under which Medicare[7] started in the 1960s were very different than they are now and will be in the future. The population was smaller and younger. The number and cost of services that were regarded as medically necessary were less. With an aging population and an explosion of technology that permits the health care system to offer many more services, Medicare has begun to show stresses and strains over time. Today that stress shows up in the form of rising costs, dissatisfaction and questions about what new health services should be covered.

Adjusting for inflation and population growth, between 2000 and 2020 total health care spending in Canada, both public and private, is predicted to grow by 56% – from $2,626 per person to over $4,100 annually. Total spending will rise from $81 billion to $147."[8]

Figure 2

Per Capita Health Care Spending
(1997 Constant Dollars)



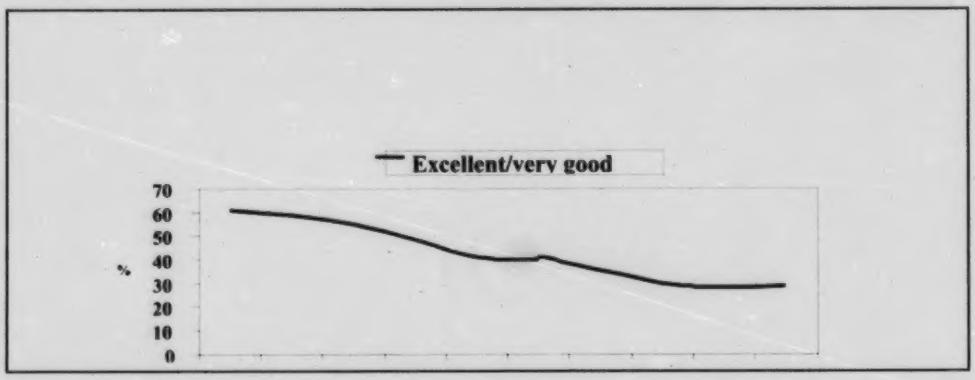
f=forecast

Source: Canadian Institute for Health Information; Conference Board of Canada.

A decade ago, a majority of Canadians (61%) were satisfied with the system; today, that number has been cut in half to fewer than one in three (29%). Canadians speak of difficulties in finding a family doctor when they move to a new community. They are concerned about how long people spend waiting in hospital emergency rooms, or to see a specialist or for surgery.

Figure 3

How Canadians Rate Their Health Care System



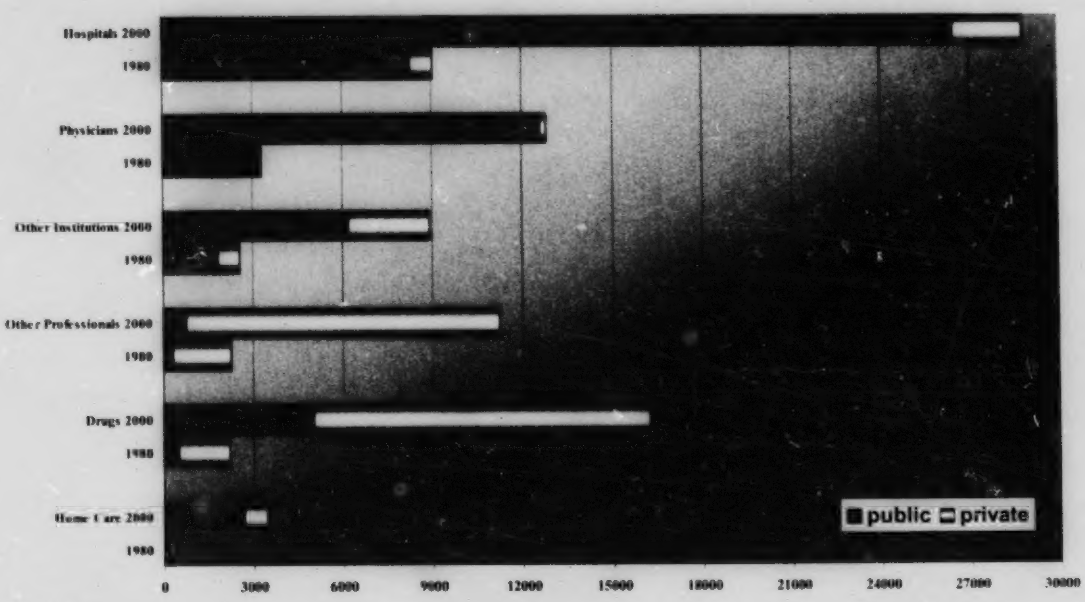
Source: Ipsos-Reid polling data as cited in Mendelsohn, Matthew, "Canadians' Thoughts on their Health Care System: Preserving the Canadian Model Through Innovation," prepared for the Commission on the Future of Health Care in Canada, Saskatoon, November 2001.

In the 1960s when Medicare was first introduced, it matched people's needs to be able to consult a doctor or go to a hospital when necessary. But times have changed, and other services are increasingly important, for example:

- **Prescription drugs are the fastest growing component of health care costs (today we actually spend more on drugs than we do on physician services) but for most people, Medicare does not cover the cost of drugs outside of hospitals;**
- **Home care has been growing rapidly, with about 1 million Canadians receiving some type of publicly funded care in their homes in 2000. Yet the extent to which such services are available or provided by the public system varies widely from province to province.**
- **There has been a dramatic rise in the use of services of professionals other than doctors such as chiropractors, physiotherapists and dentists. While the combined amount spent on their services continues to lag that spent on physicians, the vast majority of the growth in spending has been private spending.[9]**

Figure 4

Health Expenditures by Selected Categories
1980 and 2000 (million $)

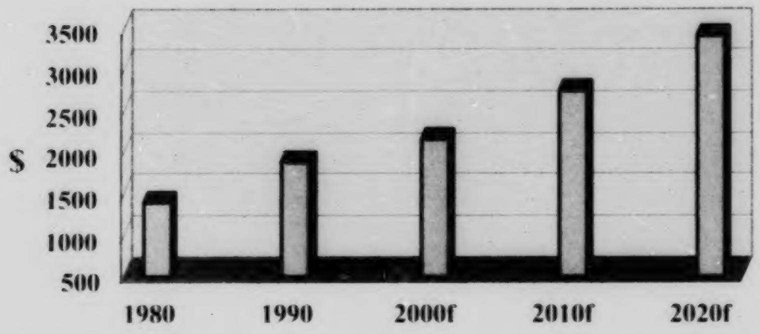


N. B.: Other Professionals are dentists, chiropractors, physiotherapists, etc.
Source: Health Canada, "Health Expenditures in Canada by Age and Sex," Catalogue no. H21-172/2001, unpublished material.

Citizens participating in the first dialogue sessions in Montreal asked facilitators about comparisons with other countries. As a result, the project team prepared an additional wall chart (see Figure 5), based on OECD comparative data. This chart was used at subsequent dialogues.

Figure 2

Per Capita Health Care Spending (1997 Constant Dollars)



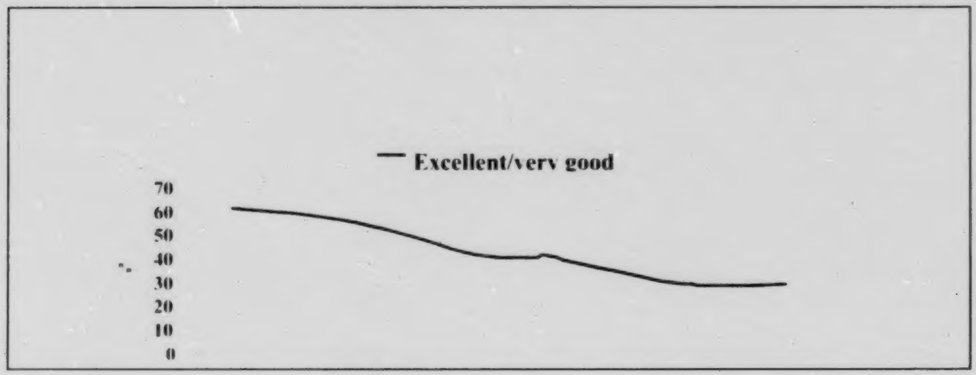
f=forecast

Source: Canadian Institute for Health Information; Conference Board of Canada.

A decade ago, a majority of Canadians (61%) were satisfied with the system; today, that number has been cut in half to fewer than one in three (29%). Canadians speak of difficulties in finding a family doctor when they move to a new community. They are concerned about how long people spend waiting in hospital emergency rooms, or to see a specialist or for surgery.

Figure 3

How Canadians Rate Their Health Care System



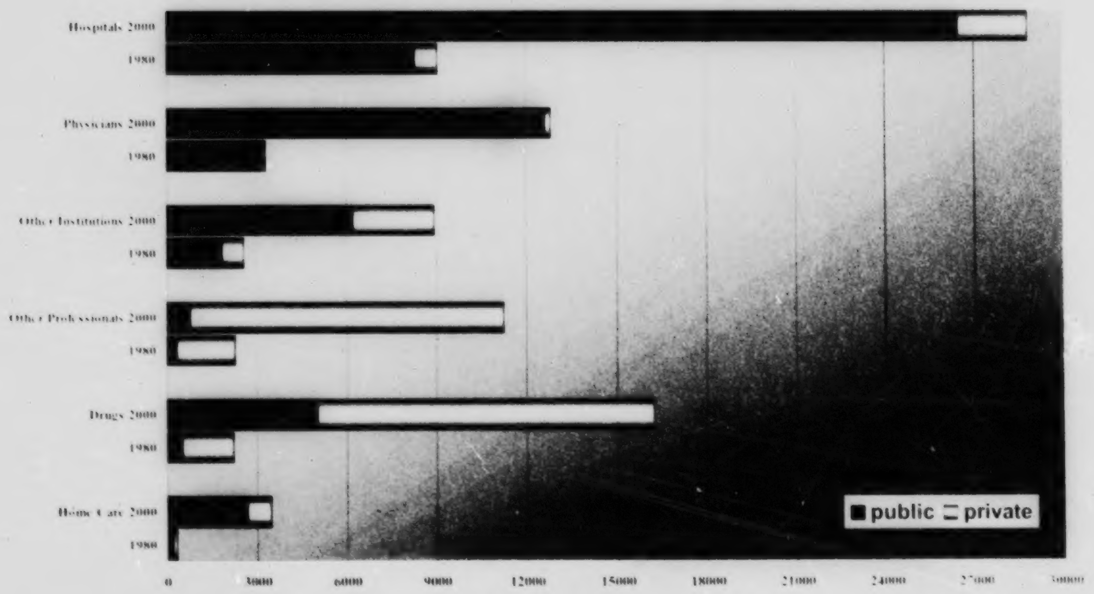
Source: Ipsos-Reid polling data as cited in Mendelsohn, Matthew, "Canadians' Thoughts on their Health Care System: Preserving the Canadian Model Through Innovation," prepared for the Commission on the Future of Health Care in Canada, Saskatoon, November 2001.

In the 1960s when Medicare was first introduced, it matched people's needs to be able to consult a doctor or go to a hospital when necessary. But times have changed, and other services are increasingly important, for example:

- Prescription drugs are the fastest growing component of health care costs (today we actually spend more on drugs than we do on physician services) but for most people, Medicare does not cover the cost of drugs outside of hospitals;
- Home care has been growing rapidly, with about 1 million Canadians receiving some type of publicly funded care in their homes in 2000. Yet the extent to which such services are available or provided by the public system varies widely from province to province.
- There has been a dramatic rise in the use of services of professionals other than doctors such as chiropractors, physiotherapists and dentists. While the combined amount spent on their services continues to lag that spent on physicians, the vast majority of the growth in spending has been private spending.[9]

Figure 4

Health Expenditures by Selected Categories 1980 and 2000 (million $)



N. B.: Other Professionals are dentists, chiropractors, physiotherapists, etc.
Source: Health Canada, "Health Expenditures in Canada by Age and Sex," Catalogue no. H21-172 2001, unpublished material.

Citizens participating in the first dialogue sessions in Montreal asked facilitators about comparisons with other countries. As a result, the project team prepared an additional wall chart (see Figure 5), based on OECD comparative data. This chart was used at subsequent dialogues.

Figure 5

How Canada Compares (2001)

	Health Outcomes[1]	*Per Capita Spending*
Japan	*1*	*15*
Sweden	*1*	*16*
Iceland	*2*	*9*
Norway	*3*	*7*
Italy	*4*	*14*
Canada	***5***	***4***
United Kingdom	*9*	*19*
France	*12*	*12*
United States	*18*	*1*

1 The measure of health outcomes was calculated as an average of the percentage change (1960-97) for male and female potential years of life lost from all causes.

Source: OECD, *Health at a Glance*. Paris: Organisation for Economic Co-operation and Development, 2001.

Following this synopsis of the challenges, citizens were also provided with some background information of a general nature, without the specifics of the individual provincial health care systems. These specifics were unnecessary as the project was never intended to provide data about the satisfaction of citizens with their particular systems. Highlights of the background section of the workbook are repeated here.

Solutions to our current problems must be found within Canada's constitutional arrangements whereby provincial governments are responsible for delivering health care and the federal government gives the provinces money to spend in accordance with the principles of the Canada Health Act. The federal government also plays a direct role in health protection and promotion, disease prevention, research and in providing health care for certain groups like Canada's First Nations.

Of the $67.6 billion in public funds spent on health care in 2000, the provinces provided about 65% , the federal government 35%.[10]

About 70% of total spending on health care in Canada is from public funds. The remaining 30% is paid by Canadians out of their own pockets or through private insurance and goes principally for dental care, vision care, prescription drugs, home care, long-term care and the services of professionals other than doctors such as chiropractors, physiotherapists and naturopaths.

Today, Medicare pays 100% of the cost of all medically necessary services provided by doctors and in hospitals. Compared to most industrialized countries, Canada provides more publicly funded coverage for hospital and physician care, and less for other services such as prescription drugs and dental care.

Figure 5

How Canada Compares (2001)

	Health Outcomes[1]	*Per Capita Spending*
Japan	*1*	*15*
Sweden	*1*	*16*
Iceland	*2*	*9*
Norway	*3*	*7*
Italy	*4*	*14*
Canada	*5*	*4*
United Kingdom	*9*	*19*
France	*12*	*12*
United States	*18*	*1*

[1] The measure of health outcomes was calculated as an average of the percentage change (1960-97) for male and female potential years of life lost from all causes.

Source: OECD, *Health at a Glance*, Paris: Organisation for Economic Co-operation and Development, 2001.

Following this synopsis of the challenges, citizens were also provided with some background information of a general nature, without the specifics of the individual provincial health care systems. These specifics were unnecessary as the project was never intended to provide data about the satisfaction of citizens with their particular systems. Highlights of the background section of the workbook are repeated here.

Solutions to our current problems must be found within Canada's constitutional arrangements whereby provincial governments are responsible for delivering health care and the federal government gives the provinces money to spend in accordance with the principles of the Canada Health Act. The federal government also plays a direct role in health protection and promotion, disease prevention, research and in providing health care for certain groups like Canada's First Nations.

Of the $67.6 billion in public funds spent on health care in 2000, the provinces provided about 65% , the federal government 35%.[10]

About 70% of total spending on health care in Canada is from public funds. The remaining 30% is paid by Canadians out of their own pockets or through private insurance and goes principally for dental care, vision care, prescription drugs, home care, long-term care and the services of professionals other than doctors such as chiropractors, physiotherapists and naturopaths.

Today, Medicare pays 100% of the cost of all medically necessary services provided by doctors and in hospitals. Compared to most industrialized countries, Canada provides more publicly funded coverage for hospital and physician care, and less for other services such as prescription drugs and dental care.

The Scenarios

The project team devoted considerable time and effort to preparing the four scenarios. Experience has shown that scenarios are an especially effective format to communicate much complex information to citizens in ways they can quickly understand and use. The scenarios were presented as a starting point only, and citizens were encouraged to change and combine their various elements and to add their own. This they did, weaving elements of different scenarios into their own vision of a desirable future for health care in Canada, and then the trade-offs they were prepared to make or support to realize that vision.

Public opinion research was an essential resource for building the scenarios, and to this end, Matthew Mendelsohn of Queen's University prepared a background paper on the trends in Canadians' attitudes, values and preferences over the past decade. A small group of experts assisted in framing the four choices and vetting the workbook. Many researchers were contacted and provided advice on issues, data, other contacts and sources. They shared their unpublished work and directed the team to published sources.

Past experience with this methodology has demonstrated that most people can comfortably handle a maximum of four scenarios in the time available. It is important to understand that scenarios are not policy options, they are stories about the future designed to bring to the surface the values of those who work with them. One member of the project team labelled them "value catchers" after the "dream catchers" used by Canada's First Nations.

To do their job, good scenarios need to be plausible so that participants will explore them seriously and not reject them out of hand. They need to be challenging and balanced – leading to both good and bad outcomes that are made explicit in each scenario (in the pros and cons listed for each), so that participants can work through the trade-offs. They need to be internally consistent and phrased in language that is easily understood. And they need to be relevant to the lives and experiences of ordinary citizens.

This was a key reason why the team chose a primary care reform scenario as opposed to acute care, long-term care, or high technology care. Chances are that all Canadians have had experience with primary care and typically access the larger health care system through their family physician as the entry point. It was also an obvious choice because primary care reform has been a central recommendation by the recent health care commissions in Alberta, Saskatchewan and Quebec.

It was decided ultimately to present four scenarios:[11]

- a "status quo plus" option (i.e., more public investment);
- an "alternative revenue raising option" (i.e., copayments that would also deter misuse);

- an option of "systemic reform through creation of a parallel private system" (i.e., increased private choice through private payment for privately provided services); and,

- an option of "systemic reform of the current system" (i.e., reorganizing primary care service delivery).

Each scenario was then written using six headings: an introduction, background information, survey results, key elements, pros, and cons. The descriptions of the scenarios, especially the pros and cons, were checked with a variety of experts who have different viewpoints to ensure that their presentation was accurate and fairly balanced. As a further check, each scenario was reviewed to ensure it clearly dealt with four key dimensions: coverage, access, decision making/accountability, and financing.[12]

The scenarios that resulted were summarized for participants as follows (the full workbook is attached as Appendix 5):

The Four Scenarios

- *More public investment.* Add more resources such as doctors, nurses, and medical equipment to deal with Medicare's current problems either through a tax increase or by re-allocating funds from other government programs.

- *Share the costs and responsibilities.* Add more resources to deal with current problems not by increasing public spending but through a system of user copayments for health care services that would provide an incentive for people not to over-use the system as well as needed funds.

- *Increase private choice.* Give Canadians increased choice in accessing private providers for health care services. Side-by-side with the public system, Canadians could also access health care services from a private sector provider (either for-profit or not-for-profit) and pay for it from their own resources or private insurance.

- *Re-organize service delivery.* Re-organize service delivery in order to provide more integrated care, realize efficiencies and expand coverage. Each Canadian would sign up with a health care provider network who would work as a team to provide more coordinated, cost-effective services and improved access to care.

The next chapter deals with the values of Canadians as they were revealed through the dialogues.

III Canadians' Health Care Values

Values are "relatively stable cultural propositions about what is deemed to be good or bad by a society."[13] This chapter outlines citizens' values for health care as they emerged when citizens explained why they were making specific choices about the health care system. The choices they made for health care are described in Chapters IV and V. This chapter also compares citizens' current values with those that emerged from the National Forum on Health values research in 1996,[14] showing how Canadians' values have evolved in the past six years.

How core values are identified and brought to bear on choices is not a linear exercise. Some values are first expressed by citizens in their introductory comments and resonate with everyone in the room. Others only surface as citizens struggle with a trade-off and realize that a particular direction or choice contradicts a deeply held value. Certain values begin as potentially commonly held positions, only to be eventually rejected. Others are unable to stand as "cultural" propositions at the end of the day as they are held by far fewer than the majority, even though they remain very important to some.

For most citizens the dialogue session was a challenging voyage and, by the end, many were able to articulate the "sacrifices" or trade-offs they were prepared to make in order to conserve and improve what they most value in our health care system. The result is a very distinctive Canadian "model" for health care, which is seen as an important part of common citizenship. In short, these citizens articulated an updated version of the health care contract with governments, first established when Medicare was introduced between 1968 and 1972 (see the box entitled Health Care Values). They also came to realize the extent to which this is also a contract among citizens.

Health Care Values

Universality… everyone is included.
Equity… individual access is based on need.
Solidarity… we are in this together – we all contribute to health care and take from it when we need to.
Fairness… we contribute based on means.
Quality… care is timely and responsive.
Wellness… prevention is key.
Efficiency… sound management and responsible behaviour ensure value for money.
Accountability… everyone is accountable for how they use or affect the system; decision making and spending are transparent.

The Core Values in 2002

Universality… Everyone Is Included

The value of universality is deeply and commonly held. In session after session, individuals would say "keep universality," "I'm worried about universality," and "I support universality." Universality is understood to mean that everyone receives the essential medical services. To give operational meaning to this value, citizens accept the principle currently found in the *Canada Health Act* (CHA) – everyone must be entitled to public health insurance coverage on uniform terms and conditions. Many also make the link to the associated value of pooling risk through a single risk pool.

Equity… Equal Access Is Based on Need

Directly linked to universality is equity. People are to be treated equally regardless of their social or economic status. Indeed citizens sometimes used the phrases of universality and equal access interchangeably. "Accessibility for everyone," "universal accessibility" and "I support universality and accessibility" were phrases repeated often and they resonated with most. Although they explored changes to the system that would jettison this value, at the end of the day citizens overwhelmingly concurred with the existing CHA principle of accessibility – individual access to health care based on need, not ability to pay.

"My message is to keep it universal, keep everyone on an equal playing field when it comes to health care." [Vancouver]

"I came with an open mind. I came this morning with the idea that a two-tiered system and user fees was the way to go for the future. Since then I changed my mind. I think we need more of a universal system where everyone has access to the same services." [Regina]

"The problem or the situation of the health care system in Canada is very complex, it won't be easy to resolve. My wish is that Canada's health insurance program will remain universal, accessible to all, rich and poor." [Translation] [Bathurst]

Solidarity… We Are in This Together

The health care contract is not just between citizens and their governments. It is also a contract among citizens. Participants expressed a strong sense of togetherness and of collective ownership for the system. They talked openly about their mutual responsibility – a sense of reciprocity. If they want the system to be there when they are sick, they must also consider the needs of others. This sense of collective ownership and of a shared resource gained momentum over the course of each dialogue, as citizens began to realize that the others in the room, who were complete strangers at 8:30 in the morning, share the same core values about health care. "We are all in this together."

"We stood as one despite our demographics. We're leaving with solidarity. It is part of being Canadian." [Halifax, Day 1]

"I've come to the realization for myself that a parallel public/private system would destroy an important part of what it is to be Canadian. I think what sets us apart is that we care a great deal for the other people in our communities." [Ottawa]

"I got a better sense of what it is to be a Canadian and that sense of community I saw here today... I saw here a group of people... who want a better system for themselves and their family and for the citizens around them." [Thunder Bay]

"We're all together in this thing... to improve our publicly funded system." [Calgary]

"One thing I've realized today, because I haven't had a lot of experience with the health care system, is that it's very important to Canadians... it seems to be something everyone feels passionate about." [Vancouver]

It is this value of solidarity – the sense of shared community, coupled with equity, fairness and universality – that pushed most citizens, by the end of the day, to their prime conclusion: that a publicly financed system is the only one that fully meets the requirements of their social values.

Fairness... We Contribute Based on Means

Associated with solidarity is fairness. Citizens do not believe that any one should be denied medically necessary care or receive lesser quality care because they are unable to pay. Fairness became the determining value as people made their choices about who should pay and how payment should be made. With health care being a public good, they believe that people should contribute to it based on their means, and this lead them back to the tax system.

Fairness also lead citizens to worry about the impact on the next generation. As they see themselves aging, people hesitate to pass their own health care costs on to their children through the tax system. They look for a balance in protecting fairness in the present and the future.

The Core Values in 2002

Universality… Everyone Is Included

The value of universality is deeply and commonly held. In session after session, individuals would say "keep universality," "I'm worried about universality," and "I support universality." Universality is understood to mean that everyone receives the essential medical services. To give operational meaning to this value, citizens accept the principle currently found in the *Canada Health Act* (CHA) – everyone must be entitled to public health insurance coverage on uniform terms and conditions. Many also make the link to the associated value of pooling risk through a single risk pool.

Equity… Equal Access Is Based on Need

Directly linked to universality is equity. People are to be treated equally regardless of their social or economic status. Indeed citizens sometimes used the phrases of universality and equal access interchangeably. "Accessibility for everyone," "universal accessibility" and "I support universality and accessibility" were phrases repeated often and they resonated with most. Although they explored changes to the system that would jettison this value, at the end of the day citizens overwhelmingly concurred with the existing CHA principle of accessibility – individual access to health care based on need, not ability to pay.

> *"My message is to keep it universal, keep everyone on an equal playing field when it comes to health care." [Vancouver]*
>
> *"I came with an open mind. I came this morning with the idea that a two-tiered system and user fees was the way to go for the future. Since then I changed my mind. I think we need more of a universal system where everyone has access to the same services." [Regina]*
>
> *"The problem or the situation of the health care system in Canada is very complex, it won't be easy to resolve. My wish is that Canada's health insurance program will remain universal, accessible to all, rich and poor." [Translation] [Bathurst]*

Solidarity… We Are in This Together

The health care contract is not just between citizens and their governments. It is also a contract among citizens. Participants expressed a strong sense of togetherness and of collective ownership for the system. They talked openly about their mutual responsibility – a sense of reciprocity. If they want the system to be there when they are sick, they must also consider the needs of others. This sense of collective ownership and of a shared resource gained momentum over the course of each dialogue, as citizens began to realize that the others in the room, who were complete strangers at 8:30 in the morning, share the same core values about health care. "We are all in this together."

"We stood as one despite our demographics. We're leaving with solidarity. It is part of being Canadian." [Halifax, Day 1]

"I've come to the realization for myself that a parallel public/private system would destroy an important part of what it is to be Canadian. I think what sets us apart is that we care a great deal for the other people in our communities." [Ottawa]

"I got a better sense of what it is to be a Canadian and that sense of community I saw here today... I saw here a group of people... who want a better system for themselves and their family and for the citizens around them." [Thunder Bay]

"We're all together in this thing... to improve our publicly funded system." [Calgary]

"One thing I've realized today, because I haven't had a lot of experience with the health care system, is that it's very important to Canadians... it seems to be something everyone feels passionate about." [Vancouver]

It is this value of solidarity – the sense of shared community, coupled with equity, fairness and universality – that pushed most citizens, by the end of the day, to their prime conclusion: that a publicly financed system is the only one that fully meets the requirements of their social values.

Fairness... We Contribute Based on Means

Associated with solidarity is fairness. Citizens do not believe that any one should be denied medically necessary care or receive lesser quality care because they are unable to pay. Fairness became the determining value as people made their choices about who should pay and how payment should be made. With health care being a public good, they believe that people should contribute to it based on their means, and this lead them back to the tax system.

Fairness also lead citizens to worry about the impact on the next generation. As they see themselves aging, people hesitate to pass their own health care costs on to their children through the tax system. They look for a balance in protecting fairness in the present and the future.

"The fact is I'm 51 and Mark is 19. I'm a member of a large group of people, my health care needs are increasing. He's part of a smaller group that's going to have to support the system in the future. If I don't start paying more than I have been, Mark is going to have to pay for it. My children will have to pay it... to put it off on Mark's generation is not fair." [Halifax, Day 2]

"Now we have equal access for a fair price – we are on the right track." [Calgary]

"I lived half my life without Medicare. We must keep the principles... paying through income tax is the only fair way." [Halifax, Day 1]

"My hope is that the coming wave of baby boomers, which is already there in the health care system, will act in a way that it will cost a lot of money, but I hope it won't create a debt that the next generation will have to take on." [Translation] [Montreal, Day 2]

Quality... Timely and Responsive Care

To experts, quality and choice have technical definitions. Quality refers to medical error or to comparisons of treatment protocols. Choice means freedom to select one's own provider and method of payment.

To citizens, quality means timely access to care that is efficient and well coordinated. There was very little discussion of medical error and, to citizens, choice meant being empowered with the ability to influence the way their care is delivered and what treatment decisions are made. They want health care with a human touch, a system that is patient-centred and thus responsive to individual needs, where the citizen can influence key choices (e.g. the choice of the doctor within a rostered system). This value opens the door to a more expansive definition of the comprehensiveness principle of the *Canada Health Act* to include new services and alternative treatments.

"I'm concerned about the lack of specialists in Saskatchewan and how long we have to wait." [Regina].

"I find it interesting that we can get MRIs for dogs but have long waiting lists for people." [Regina]

"Access to the system is diminishing. I am worried about people waiting for 14-15 hours in emergency and gurneys in the hallways." [Ottawa]

"Finding a doctor here is almost impossible and it is causing problems in the emergencies." [Ottawa]

"Why do we have to wait in ER for hours and hours?" [Halifax, Day 2]

"I'm happy that a lot of other people share the same opinion about the choice of alternative health care which I strongly wanted to point out." [Vancouver]

"I'd really like an emphasis on prevention, alternative methods [of health care], education and resource materials so I can better prepare myself when I go to the doctor's office." [Thunder Bay]

Wellness... Prevention Is Key

Talk of wellness and prevention was so pervasive across the country that observers began to wonder whether Canada is on the cusp of a societal shift. The theme was heard from sick people and healthy people, men and women, old and young, rich and poor. Citizens are especially concerned about the lack of good nutrition and exercise for children – "couch potatoes" – and about the loss of physical education and public health nurses in schools.

Wellness was spoken of in opening statements, reiterated in closing remarks. It resonated so effectively that people who did not think to mention it in the morning were speaking, at the end of the day, of "wanting their children to learn how to take care of themselves" and of "how education and prevention are key for the long-term benefit of the system." Many closed the discussion by saying that they had begun to re-think their personal responsibility for maintaining their own health.

> *"The fact is I'm 51 and Mark is 19. I'm a member of a large group of people, my health care needs are increasing. He's part of a smaller group that's going to have to support the system in the future. If I don't start paying more than I have been, Mark is going to have to pay for it. My children will have to pay it... to put it off on Mark's generation is not fair." [Halifax, Day 2]*
>
> *"Now we have equal access for a fair price – we are on the right track." [Calgary]*
>
> *"I lived half my life without Medicare. We must keep the principles... paying through income tax is the only fair way." [Halifax, Day 1]*
>
> *"My hope is that the coming wave of baby boomers, which is already there in the health care system, will act in a way that it will cost a lot of money, but I hope it won't create a debt that the next generation will have to take on." [Translation] [Montreal, Day 2]*

Quality... Timely and Responsive Care

To experts, quality and choice have technical definitions. Quality refers to medical error or to comparisons of treatment protocols. Choice means freedom to select one's own provider and method of payment.

To citizens, quality means timely access to care that is efficient and well coordinated. There was very little discussion of medical error and, to citizens, choice meant being empowered with the ability to influence the way their care is delivered and what treatment decisions are made. They want health care with a human touch, a system that is patient-centred and thus responsive to individual needs, where the citizen can influence key choices (e.g. the choice of the doctor within a rostered system). This value opens the door to a more expansive definition of the comprehensiveness principle of the *Canada Health Act* to include new services and alternative treatments.

"I'm concerned about the lack of specialists in Saskatchewan and how long we have to wait." [Regina].

"I find it interesting that we can get MRIs for dogs but have long waiting lists for people." [Regina]

"Access to the system is diminishing. I am worried about people waiting for 14-15 hours in emergency and gurneys in the hallways." [Ottawa]

"Finding a doctor here is almost impossible and it is causing problems in the emergencies." [Ottawa]

"Why do we have to wait in ER for hours and hours?" [Halifax, Day 2]

"I'm happy that a lot of other people share the same opinion about the choice of alternative health care which I strongly wanted to point out." [Vancouver]

"I'd really like an emphasis on prevention, alternative methods [of health care], education and resource materials so I can better prepare myself when I go to the doctor's office." [Thunder Bay]

Wellness… Prevention Is Key

Talk of wellness and prevention was so pervasive across the country that observers began to wonder whether Canada is on the cusp of a societal shift. The theme was heard from sick people and healthy people, men and women, old and young, rich and poor. Citizens are especially concerned about the lack of good nutrition and exercise for children "couch potatoes" – and about the loss of physical education and public health nurses in schools.

Wellness was spoken of in opening statements, reiterated in closing remarks. It resonated so effectively that people who did not think to mention it in the morning were speaking, at the end of the day, of "wanting their children to learn how to take care of themselves" and of "how education and prevention are key for the long-term benefit of the system." Many closed the discussion by saying that they had begun to re-think their personal responsibility for maintaining their own health.

"My key insight is the fact that a majority believe like me that prevention is key and this is a surprise." [Ottawa]

"Everyone believes that more prevention and education are needed and that they can reduce costs." [Vancouver]

"Need to make people aware of their responsibility for their own health." [Translation] [Québec City]

"Today, no way ... What can I do to be in shape, be like my 84-year-old father ... It's simple, by doing a bit of physical exercise, by encouraging me to be physically active. ... Not through financial incentives ... by showing me testimonials from people who are 75 or 80 years old who have invested in health, who are in physical shape. How did they manage to live, give us the recipes and teach that to our kids." [Translation] [Québec City]

Efficiency... Sound Management and Responsible Behaviour Ensure Value for Money

Efficiency became the core value underlying a number of citizens' choices and trade-offs. Citizens were dismayed by what they perceived as the inefficiency of the existing health care system. (In the French speaking groups, the critique was the same but the expression used most frequently was *la gestion.*)

They believe that unnecessary use by patients, the repetition of assessments and other actions by providers, the duplication of effort as layers of government second-guess each other, and the highly politicized dynamic between federal and provincial governments are imposing significant extra costs on the taxpayer.

Citizens want to see greater efficiency in order to preserve and protect the best of the system and make it sustainable for the future. Health resources (financial, professional, and technological) are scarce and they are to be shared, meaning they have to be used sparingly. As users/funders/owners, citizens are prepared to limit their own "consumer" choices to conserve scarce resources and they expect others to adopt changes compatible with this value. Most importantly, until they see evidence of efficiency measures, citizens will not support higher taxes as the means to add more resources to the system.

"There are administrative paper-work reforms that could save some money. But also the costs of double administration... reducing the redundancies." [Vancouver]

"We've got a federal health level, provincial health level, regional boards, local health authorities, hospital authorities, and every time you've got a question, they say 'I'll refer you to the other authority,' so the bureaucracy has to be trimmed somehow at one level or another." [Vancouver]

"What I found most mind boggling today is that I think everybody was thinking the same thing. All the shots were aimed in the same direction: efficiency, efficiency [sound management]. I think this is an important message for the government." [Translation] [Québec City]

"I live in a remote region, therefore where there are problems that I don't seem to detect almost anywhere in large centres. Within the existing system, in Quebec, not everything needs to be discarded, it all rests on healthy management, financial as well as human resources, and the concept of reorganisation and readjustment." [Translation] [Québec City]

Accountability... Everyone Is Accountable for How They Use or Affect the System; Spending Must Be Transparent

Citizens want all actors in the health care system to be accountable for their performance and the consequences of their actions. Inappropriate use of the system has to be monitored and corrected. Citizens across the dialogues were able to articulate their own personal responsibility and then create a map of accountabilities for providers and managers, private corporations and governments (discussed in Chapter V). In effect, they argued that all the players in the system have a stewardship function to ensure that existing health care resources are used effectively.

Citizens were seeking clarity. The confusion in the roles of governments makes it difficult for them to know who is accountable for what. They also blamed the inter-governmental quarrels for inefficiency in the system because important decisions are delayed by health care politics.

In every dialogue there were calls for transparency. Citizens want to be able to trace the dollar they pay in taxes right through to the point where it gets spent on health care.

"My key insight is the fact that a majority believe like me that prevention is key and this is a surprise." [Ottawa]

"Everyone believes that more prevention and education are needed and that they can reduce costs." [Vancouver]

"Need to make people aware of their responsibility for their own health." [Translation] [Québec City]

"Today, no way ... What can I do to be in shape, be like my 84-year-old father ... It's simple, by doing a bit of physical exercise, by encouraging me to be physically active. ... Not through financial incentives ... by showing me testimonials from people who are 75 or 80 years old who have invested in health, who are in physical shape. How did they manage to live, give us the recipes and teach that to our kids." [Translation] [Québec City]

Efficiency... Sound Management and Responsible Behaviour Ensure Value for Money

Efficiency became the core value underlying a number of citizens' choices and trade-offs. Citizens were dismayed by what they perceived as the inefficiency of the existing health care system. (In the French speaking groups, the critique was the same but the expression used most frequently was *la gestion.)*

They believe that unnecessary use by patients, the repetition of assessments and other actions by providers, the duplication of effort as layers of government second-guess each other, and the highly politicized dynamic between federal and provincial governments are imposing significant extra costs on the taxpayer.

Citizens want to see greater efficiency in order to preserve and protect the best of the system and make it sustainable for the future. Health resources (financial, professional, and technological) are scarce and they are to be shared, meaning they have to be used sparingly. As users/funders/owners, citizens are prepared to limit their own "consumer" choices to conserve scarce resources and they expect others to adopt changes compatible with this value. Most importantly, until they see evidence of efficiency measures, citizens will not support higher taxes as the means to add more resources to the system.

"There are administrative paper-work reforms that could save some money. But also the costs of double administration... reducing the redundancies." [Vancouver]

"We've got a federal health level, provincial health level, regional boards, local health authorities, hospital authorities, and every time you've got a question, they say 'I'll refer you to the other authority,' so the bureaucracy has to be trimmed somehow at one level or another." [Vancouver]

"What I found most mind boggling today is that I think everybody was thinking the same thing. All the shots were aimed in the same direction: efficiency, efficiency [sound management]. I think this is an important message for the government." [Translation] [Québec City]

"I live in a remote region, therefore where there are problems that I don't seem to detect almost anywhere in large centres. Within the existing system, in Quebec, not everything needs to be discarded, it all rests on healthy management, financial as well as human resources, and the concept of reorganisation and readjustment." [Translation] [Québec City]

Accountability... Everyone Is Accountable for How They Use or Affect the System; Spending Must Be Transparent

Citizens want all actors in the health care system to be accountable for their performance and the consequences of their actions. Inappropriate use of the system has to be monitored and corrected. Citizens across the dialogues were able to articulate their own personal responsibility and then create a map of accountabilities for providers and managers, private corporations and governments (discussed in Chapter V). In effect, they argued that all the players in the system have a stewardship function – to ensure that existing health care resources are used effectively.

Citizens were seeking clarity. The confusion in the roles of governments makes it difficult for them to know who is accountable for what. They also blamed the inter-governmental quarrels for inefficiency in the system because important decisions are delayed by health care politics.

In every dialogue there were calls for transparency. Citizens want to be able to trace the dollar they pay in taxes right through to the point where it gets spent on health care.

Accountability and efficiency were intertwined in citizens' minds. Both surfaced in opening statements and gained momentum as citizens struggled with the choices of "how to pay" for their preferred system. Citizens were adamant that much needs to be done to reform day-to-day operations based on these two values. While they did not make the link to the principle of public administration in the *Canada Health Act*, it is clear that this principle or the existing interpretation of it does not satisfy citizens' expectations.

"Medicare is very, very important to Canadians. But accountability is essential. I demand accountability as far as spending of our tax dollars." [Montreal, Day 1]

"I've seen a lot of misspending and a lack of accountability. And because of that I don't have a lot of confidence in the government today. Not only provincially but federally. So if I knew there was some accountability, I wouldn't mind spending more money for the services I was being provided." [Regina]

"We need is an independent auditor general, who is not appointed by the government, to review and ensure that the administration of costs and the health care system itself are cleaned up." [Translation] [Québec]

"We need to persuade Canadians to be more accountable for their health. When I think back I know lots of people who could have made different choices and reduced costs of the care they now need." [Ottawa]

"I'm convinced there's tons of money in the system. But it is frittered away and no one is accountable. We have to have a much stricter set of criteria of how that money is spent." [Toronto]

"I'd like to be confident that there's a good measuring system, measuring results and efficiencies, that could be used to delegate more authority to regional and sub-regional boards... getting them more effective management tools." [Calgary]

Continuity and Change

In 1996, the National Forum commissioned a survey of 803 Canadians in 9 communities and then engaged 93 of those people in focus group sessions, where they reviewed scenarios depicting specific health care choices facing providers and patients. They had a short time to deliberate on the trade-offs illustrated in the scenarios. The Forum identified a set of core values similar to many of the values described above, but was not able to link them to policy choices.[15]

Six years later, using a more intensive day-long process, the Citizens' Dialogue has produced a remarkably different result for two reasons. First, citizens have moved on

Accountability and efficiency were intertwined in citizens' minds. Both surfaced in opening statements and gained momentum as citizens struggled with the choices of "how to pay" for their preferred system. Citizens were adamant that much needs to be done to reform day-to-day operations based on these two values. While they did not make the link to the principle of public administration in the *Canada Health Act*, it is clear that this principle or the existing interpretation of it does not satisfy citizens' expectations.

"Medicare is very, very important to Canadians. But accountability is essential. I demand accountability as far as spending of our tax dollars." [Montreal, Day 1]

"I've seen a lot of misspending and a lack of accountability. And because of that I don't have a lot of confidence in the government today. Not only provincially but federally. So if I knew there was some accountability, I wouldn't mind spending more money for the services I was being provided." [Regina]

"We need is an independent auditor general, who is not appointed by the government, to review and ensure that the administration of costs and the health care system itself are cleaned up." [Translation] [Québec]

"We need to persuade Canadians to be more accountable for their health. When I think back I know lots of people who could have made different choices and reduced costs of the care they now need." [Ottawa]

"I'm convinced there's tons of money in the system. But it is frittered away and no one is accountable. We have to have a much stricter set of criteria of how that money is spent." [Toronto]

"I'd like to be confident that there's a good measuring system, measuring results and efficiencies, that could be used to delegate more authority to regional and sub-regional boards... getting them more effective management tools." [Calgary]

Continuity and Change

In 1996, the National Forum commissioned a survey of 803 Canadians in 9 communities and then engaged 93 of those people in focus group sessions, where they reviewed scenarios depicting specific health care choices facing providers and patients. They had a short time to deliberate on the trade-offs illustrated in the scenarios. The Forum identified a set of core values similar to many of the values described above, but was not able to link them to policy choices.[15]

Six years later, using a more intensive day-long process, the Citizens' Dialogue has produced a remarkably different result for two reasons. First, citizens have moved on.

The "reforms" and cuts to health care services in the first half of the 1990s did not lead to better system performance, nor did the massive re-injection of funds in the past five years. Citizens are now more critical, more skeptical about policy, and more concerned than ever about the sustainability of the Medicare model. More generally, they are much more aware of the constraints imposed by tougher economic times, and therefore more demanding of value for money from the health care system.

Second, the dialogue methodology used in this project did not allow citizens to avoid the tough choices. With the benefit of more time and a set of scenarios focused on systemic choices, rather than individual dilemmas, the vast majority of participants did come to a final judgment on the broad outline of the health care contract. And that judgment rejects the status quo.

The Canadian Model – 2002

Citizens gained a sense of ownership of the health care system through the dialogue process. They went beyond their roles as users or consumers, to see themselves as owners, investors, and stakeholders. Their final judgment, at the end of day, expresses the essence of a health care contract. This contract is both among citizens themselves, and between citizens and the players responsible for the system – providers, managers and governments.

The health care contract imagined by Canadians in 2002 is different from the past. In the mid-1960s, when Medicare was introduced, one of the major goals was to protect citizens from personal bankruptcy. In 1984, when the *Canada Health Act* was introduced, the main focus was on buttressing universality and equal access. In 1996, when the National Forum on Health did its research on health care values, citizens were highly resistant to changes in the system. Now, in 2002, citizens who are given the opportunity to reflect deeply on the challenges we face are ready for change. They want to preserve the essence of Medicare, but they reject the status quo as unsustainable.

The most important shift since 1996 is the introduction of explicit economic and political values into the health care contract. Efficiency and accountability were part of the value set identified by the Forum, but they were not articulated in health care choices, as they were in this dialogue. Universality and equity have always been there and remain the bedrock. Citizens want to keep the essence of the Medicare model but, in order to sustain it, they see the need both to reform the design and functioning of the health care system and to make changes in their own behaviour.

The mix of values includes:

- **The social values**. Canadians genuinely believe that this society will be better off if the risks of poor health are pooled for everyone. Citizens see health care as a public good, a shared resource, and an asset to be passed on to future generations. Citizens believe that people should contribute fairly on the basis of their incomes and have the right to use health care according to medical need.

- **The political values.** Participants speak openly about their rights and responsibilities as citizens. They believe they have a right to equal access and to efficient and responsive health care. But they also establish a list of personal responsibilities for which they are to be held accountable. And they seek appropriate accountabilities and standards of stewardship from their fellow citizens, providers, managers, and governments. They also insist on greater transparency in how decisions are made in managing the health care system, and how money is spent.

- **The economic values.** While expressing an ongoing faith in the merits of collective institutions, they believe those institutions have a responsibility to manage health care systems effectively and efficiently and to invest in the long-term health of the population through prevention and education.

It is also important to note the values that citizens did not fully embrace at the end of the day. Here are several examples.

- Freedom of choice was part of the value set identified by the Forum and is readily endorsed in the public opinion polling in 2002. But it did not rise to the top in the Citizens' Dialogue. Participants used the expression, but they gave it a different meaning. Choice does not mean unfettered personal choice to secure quality and access based on ability to pay. What it means is empowering patients and making the system responsive to personal participation in treatment choices and alternative care options.

- The National Forum also identified collective responsibility as a core value meaning that people want to participate in decisions about their own health care system as individuals and as members of boards and advisory committees. In contrast, the Dialogue citizens added a stronger edge to this value, by linking collective responsibility to the stewardship of the system – to achieve efficiency and accountability. The harder edge shows up in their insistence that there must be consequences for inefficiency and for actions that are deleterious to health, such as environmental degradation.

- Finally, personal responsibility has evolved since 1996. Responsibility for one's health and to use the health care system responsibly remain common threads. But the Dialogue citizens also insisted on two other dimensions of personal responsibility – to adapt the way one uses the health care system to take advantage of new technologies and new ways of organizing care; and to pay one's fair share of the costs, for example through taxes earmarked for health care. In this case, citizens share the responsibility for efficiency gains, even if that means they must sacrifice some of their personal choices. However, they did not go so far as to impose financial penalties on people who do not take care of their health or do not use the system responsibly.

In summary, the unique contribution of the Citizens' Dialogue has been to enable citizens to link new and old values into a revised health care contract, updated to 2002. Citizens are trying to build a bridge to a better, financially sustainable health care system, based on the Medicare model. They used their core values and principles to give governments permission to make significant reforms. They also set some very challenging conditions for citizen consent.

"I got a better sense of what it is to be a Canadian and that sense of community I saw here today. Contrast that to the US where everybody is for himself. You get the health care you can afford to buy. I saw here a group of people who are prepared to put their money where their mouth is. They want a better system for themselves and their family and for the citizens around them." [Thunder Bay]

"I hope you would understand our desire to have a more responsible, accountable system and that we are, as Canadians, willing to participate and be responsible for our health as well. Hopefully, this will, in the long term, make effective use of our resources." [Halifax, Day 1]

"We as Canadians care about our neighbours and we are not scared of having government help us. Government is not the great evil." [Ottawa]

"I found people so generous I was surprised. . . People are ready to pay more taxes. Canada is about caring for people, it is about freedom and choice." [Ottawa]

on the Medicare model. They used their core values and principles to give governments permission to make significant reforms. They also set some very challenging conditions for citizen consent.

"I got a better sense of what it is to be a Canadian and that sense of community I saw here today. Contrast that to the US where everybody is for himself. You get the health care you can afford to buy. I saw here a group of people who are prepared to put their money where their mouth is. They want a better system for themselves and their family and for the citizens around them." [Thunder Bay]

"I hope you would understand our desire to have a more responsible, accountable system and that we are, as Canadians, willing to participate and be responsible for our health as well. Hopefully, this will, in the long term, make effective use of our resources." [Halifax, Day 1]

"We as Canadians care about our neighbours and we are not scared of having government help us. Government is not the great evil." [Ottawa]

"I found people so generous I was surprised. . . People are ready to pay more taxes. Canada is about caring for people, it is about freedom and choice." [Ottawa]

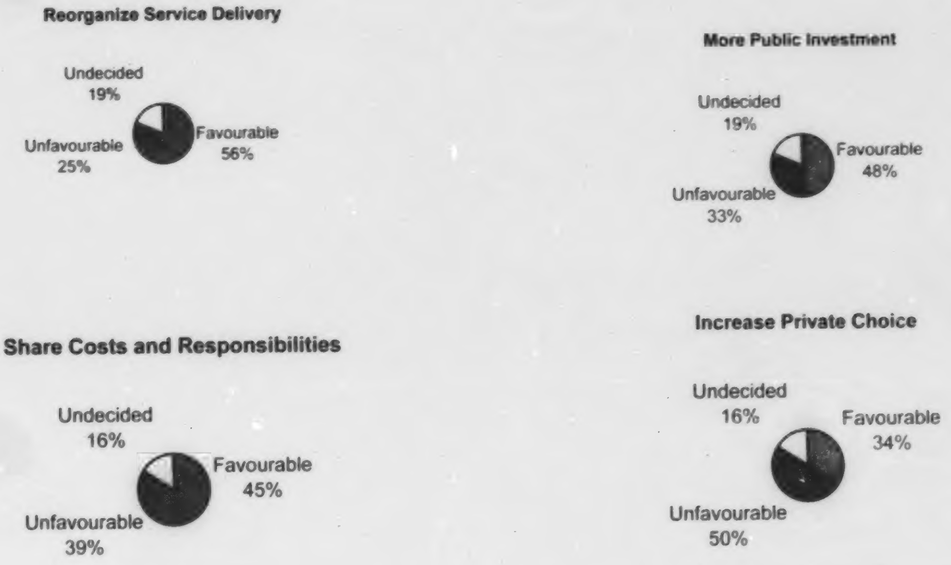
IV The Morning: Citizens' Vision of a Desirable Future for Canada's Health Care System

This chapter describes what transpired over the course of the morning as citizens outlined their initial concerns and preferences and then worked together to define a shared vision of the health care system they would like to see in Canada in 10 years. After reading the workbook and listening to the facilitator explain the purposes of the session, the agenda and the issues of concern (outlined above in Chapter II), citizens completed a questionnaire designed to measure their initial judgment. They recorded how favourable or unfavourable they felt toward each of the four scenarios using a 7-point scale.

Initial Views of the Four Scenarios

Figure 6

Pre-Dialogue Questionnaire Results



N. B.: On a seven-point scale, scores of 5-7 were interpreted as favourable, 4 as undecided, and 1-3 as unfavourable.
Source: Citizens' Dialogue on the Future of Health Care in Canada.

As the dialogues began, only one scenario, *reorganize service delivery*, was favoured by more than half of the participants and it was a slim majority of 56 percent who supported it. Taken as a whole, the results of the first questionnaire show that there was no overwhelming support for change of any sort. Less than 50 percent of citizens were prepared to invest more publicly in the system. Less than 50 percent were open to paying user fees. About one-third were receptive to increasing private choice through a parallel private system but 50 percent were opposed to this scenario (see Figure 6).

Beginning the Dialogue

With initial questionnaires completed, citizens were asked to introduce themselves and to speak briefly of a concern or an issue related to Canada's health care system about which they felt strongly. The same issues were raised time and time again. They spoke spontaneously and articulately about universality, accessibility, affordability, sustainability, inefficiency, waste and abuse, and prevention, drawing on their own experiences. Less frequently but still heard were worries about coverage and personal choice. Some questioned how real the problems are, and whether significant change is required. And there were others who were reluctant to share their own thoughts at the beginning for they had come "wanting to learn more about the system," "to educate themselves," and "interested in seeing how the process works."

The issues citizens brought to the dialogue sessions are summarized below, roughly in descending order from the most often heard to the less frequently heard at the outset of the dialogues.

Universality and Accessibility

Citizens wanted public insurance to continue to cover all Canadians equally for medically necessary care. But as they thought about the current situation and about the future, they expressed their worries about:

- the lack of resources (financial, human and equipment);
- waiting for family physicians, specialists, diagnostics, elective surgery, home care;
- whether or not low and modest income earners do receive all necessary care; and
- people in rural areas who must travel long distances to hospitals and specialized care. They believe doctors and nurses are leaving their local communities because they are overworked and under-resourced.

Affordability and Future Sustainability

A significant number said outright that they do not believe that health care is on a sustainable course. They worry about how to control costs and they were frustrated that they did not know "where all the money is going." Those without supplementary insurance worried about the costs of prescription drugs and other services that are not fully covered by Medicare.

There were diverse views about where to look for solutions:

- there was support for user fees, and opposition;
- there was opposition to tax increases, and very little support;
- there were calls for better use of current resources;
- there was insistence that cost efficiencies can be found; and
- there were suggestions that industries that encourage unhealthy habits (tobacco, alcohol, junk food) or that profit unduly from health care (prescription drugs) should pay more.

Inefficiency, Waste and Abuse

Citizens believe that all the actors – patients, providers and managers, and governments – drive costs higher through inefficiencies. They pointed to:

- patients who treat doctor visits as social outings;
- patients who shop around to several doctors for multiple prescriptions;
- patients who make inappropriate use of emergency services;
- doctors that recall patients unnecessarily;
- doctors that over-prescribe drugs;
- provincial departments that do not shrink despite the creation of regional authorities; and
- federal and provincial governments spending time fighting rather than making necessary decisions.

Prevention and Education

An oft-repeated theme was that Canadians, as individuals and collectively, should place more emphasis on illness prevention and health promotion. They saw cuts to public health programs in schools and other community settings, and to programs such as Participaction, as a false economy, that would create much greater costs later when otherwise preventable illness would have to be treated. Their views went beyond the traditional idea that" an ounce of prevention is worth a pound of cure" to encompass a broader understanding of the determinants of health as including a healthy environment, strong communities, and active lifestyles.

Coverage

Although not pervasive, there were calls for expanded coverage, especially to include home care and prescription drugs. And there were pleas for better access to expensive high technology, while others wanted more access to alternative and non-medical therapies.

Personal Choice

Some expressed their interest in exploring privatization of services to allow for greater choice and to instil new competitive dynamism into the system. Others spoke quickly in opposition to privatization and worried about introducing aggressive profit making into health care.

The Health Care System Citizens Want

With their concerns and those of others fresh in their minds, participants were asked to work together, first in small groups (of about 10) and then in plenary, to describe their desired future for health care: "What do we most want to see in our health care system 10 years from now?" Each of the groups was self-facilitated, guided by a set of ground rules for dialogue. Groups were asked first to work through each of the scenarios and define what Canada's health care system would look like in 10 years if that scenario were followed. What would be good or bad about that future? Then the groups were asked to review the good elements they had identified for each scenario and to select those they most wanted to see in the health care system in the future. Finally, the groups were asked to review their list of desirable elements and to add whatever elements they think are needed to complete the picture of the health care system they would like to see in 10 years. After working in small groups for about 90 minutes, they reconvened in plenary and created a composite desirable future, building upon the similarities in the reports of the different groups.

Their preferred future for the health care system built both on the issues, concerns and values described in their opening comments, and on the additional material contained in the workbooks.

By the end of the morning, citizens had identified the key characteristics of the health care system they want to see in Canada in 10 years and they are summarized in the box and further explained below. This vision was remarkably consistent in the 12 dialogues held from coast to coast.

The Morning: The Ideal Health Care System

Access is based on need
Coverage is universal
Accountabilities are clear for all the players
Individual needs are met in a more patient-centred system
Wellness and prevention are emphasized
Care is integrated, multi-disciplinary and convenient
The system is efficient and affordable

Access is based on need

Citizens' preferred future system would provide all citizens with medically necessary health care. Access would be based on need and not ability to pay. There was overwhelming although not unanimous support for this characteristic of the future system.

There were those who spoke up for a right to spend their own resources to receive treatment privately and not "wait, based on need" in the public system. But most of those who expressed this wish did not see it as contradicting the principle of universal coverage and access based on need. They felt that allowing people to purchase services privately if they wished actually would strengthen the public system by freeing up capacity. But most felt that increasing private choice in this way would really harm the public system, and that was not acceptable.

Coverage is universal

Necessary health care services for all citizens should be covered, but what should be included as a necessary service? Some citizens spoke in favour of expanding coverage to include home care and drugs, vision and dental care. Some suggested extending coverage to alternative practitioners such as naturopaths. There were calls for increased emphasis on non-drug-based therapies, in part because of a suspicion that drug companies are pushing expensive treatments that are sometimes of questionable value. The calls for expansion varied across the country, not surprisingly given the current differences in the coverage offered by provincial plans. But most citizens concluded they needed to concentrate their energies first on making the existing system sustainable before expanding coverage.

Accountabilities are clear for all the players

There would be increased accountabilities for patients, providers, and governments. Some went on to suggest adding to that list drug companies and industries that have an impact on the need for health care, such as polluters. But others worried about the potentially negative economic consequences of such action, and pointed out that any additional costs would be passed on to consumers.

Citizens emphasized that there needs to be much greater clarity in where the money is going, how it is spent and how decisions are made. To help ensure such transparency, they envisioned earmarking taxes to ensure that funds collected would be truly dedicated to health care and could be accounted for more effectively. And they saw a system in which the responsibilities of each government and health institution would be defined clearly, so they would know who to hold to account for what.

Individual needs are met

The preferred system would acknowledge that individual needs vary and, as a result, it would be flexible and patient centred. It would be more responsive to individuals who desired alternative therapies, who required high-technology diagnostics, who wished to be intimately involved in selecting their treatments, and who stood to benefit from new drug therapies. The system would provide a continuum of care from cradle to grave.

While very concerned about access to expensive high technology, people are at the same time not convinced that high-technology medicine is the most effective answer to every health problem. Citizens suggested that objective and critical assessment of new technology is essential to determine cost benefit relative to older processes.

Wellness and prevention are emphasized

Prevention of illness and promotion of wellness would be a priority for their health care system. But this would be a shared responsibility involving individuals, families, schools, communities and other government programming.

Care is integrated, multi-disciplinary and convenient

The team approach would be the centrepiece of the health care system. Citizens liked this approach because it would be responsive to individual needs, structured to emphasize wellness and prevention, and would offer integrated and coordinated care through a team of various professionals. Plus they liked the convenience of 24/7 services and one-stop shopping. And some hoped that a supportive and collegial team would reduce the burden on doctors, prevent burnout, and encourage health professionals to locate and stay in rural and remote areas.

The system should be efficient and affordable

The preferred system would be efficient and affordable. Health care at any cost would not be acceptable, and citizens had views of how the system could be made more affordable through adopting efficiencies. Administration would be streamlined. Diagnostic tests and assessments would be done once. The most appropriate provider would deliver care, accessed efficiently through the team. Drug costs would be lower, for example through bulk purchasing arrangements.

Future funding comes mainly from efficiency gains

Resistance to tax increases was widely voiced at the end of the morning. There was no agreement on where to look for public funds that could be reallocated to health care. There was some support for user fees, but there was also considerable unease about their impact on low-income earners; and there was outright opposition from some who said user fees meant paying twice and will discourage those less well off from seeking needed care. Participants were also divided about creating a parallel private system. While some suggested it might take pressure off the public system, others thought it would damage the public system by siphoning off the best doctors, equipment and other essential resources, and facilitating further government cutbacks.

By the end of the morning, each dialogue session had created a vision for the future of health care in Canada, and these visions were remarkably consistent across the country. However, this vision was still a wish list, to be financed mainly through the cost savings created by efficiency gains. There was clear evidence that citizens wanted to avoid any tax increases. The rest of the day was spent working through the contradictions in the wish list and determining "how to pay for what we want" to enable citizens to reach a more considered and responsible judgment.

V The Afternoon: Making Choices and Trade-offs

The afternoon was devoted to making the tough choices and trade-offs needed to realize the vision of the health care system that citizens had defined. Citizens worked in the same groups to answer the question: "How can we best move toward a desirable future for health care in Canada, what specific steps should we take?" Facilitators emphasized the importance of developing a list of steps that are mutually consistent (that do not work at cross purposes) and affordable; to be as specific as possible on the steps that should be taken and how they would be paid for. They underlined: "If we do not make the choices and trade-offs they will be made for us, and they may not be the choices we want."

To provide further guidance, the facilitators in most of the dialogues used three wall charts to indicate the sorts of questions that participants would need to answer: the first listed different ways to "pay for what we want"; the second asked participants to be specific about what constraints they were prepared to accept on how they access health care "to reduce costs and improve efficiency" under a rostered (team-based) system; and the third asked where participants would draw the line with respect to the services for which people should be able to buy private insurance. These charts are reproduced in Appendix 3.

Citizens worked together intensively in their groups for a further 90 minutes, constructing their list of suggested steps and working through the difficult choices and trade-offs. In this process, hope faded that the system could be made sustainable simply by eliminating waste and improving the efficiency of management, and citizens began to examine more deeply what needed to be done. The groups then reported their conclusions, and the balance of the dialogue was spent defining the common ground among citizens on the steps that should be taken.

Citizens' willingness to embrace reform is at the same time bold and cautious. They are willing to accept a health care system that looks very different from today but they are clear on their requirements, conditions and qualifiers that implicate all the players in the system.

The Afternoon: Making Choices

Reorganizing service delivery
Increased funding – make it public
Stronger accountability and transparency
Citizens' judgment on health reform

1. Reorganizing Service Delivery

The focus shifted to renewing the system through reforms that are consistent with the values of access based on need, fairness and efficiency. Citizens saw the potential for such gains in having a team of medical professionals (doctors, nurses, pharmacists, and others) provide more coordinated primary care, supported by a central information system. They also were very attracted by the idea that such a team would not only provide more coordinated, cost-effective care, but also would have greater incentive to focus on wellness, prevention and patient education. To make it work, they understood, would require changes in the behaviour of citizens, providers and governments. Citizens then worked through very specifically the changes they are prepared to make in how they access health care in order to help increase efficiency and lower costs in a rostered system. Some of the trade-offs came easily and were readily accepted. In others it took much more time and much dialogue with each other to come to judgment.

Alternatives to Emergency Rooms

Citizens readily agreed to access care at clinics provided by the health care network with which they are rostered, instead of using emergency rooms when there is no emergency. Some went even further and suggested that those who continue to use emergency rooms in cases of non-emergencies should be expected to pay user fees.

Alternatives to Physicians

Citizens are comfortable with nurses or nurse practitioners assessing needs (triage) and they are ready to rely on nurses to provide routine care, such as immunizations, checking progress on a surgical wound or an infection.

Investing Time in Education and Wellness

Citizens are willing and even eager to take personal action to improve and sustain their own health and wellness. They are prepared to invest their own time to learn more about prevention and changing unhealthy habits. They look forward to help from the health care network with which they are rostered and from government to sort through the contradictory health information they receive from the media, and to provide a trusted source, counselling and support to guide their choices on how to stay healthy. Citizens understand that part of the health care contract is assuming responsibility for their own health, through diet, exercise, and healthy living. Several made personal testimonials. And citizens recognize that focusing on wellness and prevention is relevant to everyone over the life course – it is a continual learning process for the young and the old.

Rostering

By the end of the afternoon, citizens were willing to sign up and receive all of their primary care from a single team of health care providers for at least a year. But there are conditions attached to this agreement.

A few accepted rostering without any discussion of conditions because it sounds like a good solution to their current difficulties in finding a family doctor. But most began with hopes that they could have the advantages of multidisciplinary teams without the downside of limiting their ability to choose or change doctors. Many worried about getting stuck with a doctor they do not like, and made acceptance of rostering conditional on being able to choose the doctor with whom they would deal within a network. The condition they spelled out is that they first have the opportunity to meet the doctor in order to assess the fit of personality, philosophy and approach to care.

In agreeing to rostering, Canadians expect responsive team-based health care, led by doctors. They were quite clear that they do not want to be tied to a commercial operation like some of the health maintenance organizations (HMO) in the United States, and emphasized that the proposed health care networks or teams in Canada must operate within the public system. Many spoke of first-hand experience with HMOs in the United States, and of the experiences there of friends and family, as a cautionary tale. HMOs are seen to be bureaucratic and to place their bottom line ahead of the needs of patients. Citizens dislike the private payment in HMOs and the limits to coverage and access.

A Conversation on Rostering, in Vancouver

"I have two children. I would need to be able to choose [my doctor] because if I'm going to sign up with a doctor and have to be there for a year, and find out three months into it that this doctor is incompetent or is doing things that are going to harm my health or my daughters' health, then I'm not going to want to deal with that doctor."

"For a lot of people that's [rostering] not going to be a problem. But there'll be a few people, they look at their doctor, he looks at them and they hate each other on sight and you're stuck with him for a year, forget it. It's not going to work... it would be very damaging to the doctor/patient relationship if you didn't have flexibility."

"If you can get [patient information] onto a database and have the information on one patient transportable between [networks], moving to another [network] shouldn't be a problem... you don't need to redo all these diagnostic tests because it's all there."

"Within networks, if it's general practitioners, what are my choices in a rural area? Is it just one doctor or two? What if either one doctor's or both doctors' values don't coincide with my core values as a user, with what my needs are and what kind of active input I want into my health care? Then I'm going to want to shop around."

"If we can guarantee that there'd be a choice of more than one doctor... there has to be some sort of out. You need to be able to shop around before you make that agreement [to roster]."

Rostering

By the end of the afternoon, citizens were willing to sign up and receive all of their primary care from a single team of health care providers for at least a year. But there are conditions attached to this agreement.

A few accepted rostering without any discussion of conditions because it sounds like a good solution to their current difficulties in finding a family doctor. But most began with hopes that they could have the advantages of multidisciplinary teams without the downside of limiting their ability to choose or change doctors. Many worried about getting stuck with a doctor they do not like, and made acceptance of rostering conditional on being able to choose the doctor with whom they would deal within a network. The condition they spelled out is that they first have the opportunity to meet the doctor in order to assess the fit of personality, philosophy and approach to care.

In agreeing to rostering, Canadians expect responsive team-based health care, led by doctors. They were quite clear that they do not want to be tied to a commercial operation like some of the health maintenance organizations (HMO) in the United States, and emphasized that the proposed health care networks or teams in Canada must operate within the public system. Many spoke of first-hand experience with HMOs in the United States, and of the experiences there of friends and family, as a cautionary tale. HMOs are seen to be bureaucratic and to place their bottom line ahead of the needs of patients. Citizens dislike the private payment in HMOs and the limits to coverage and access.

A Conversation on Rostering, in Vancouver

"I have two children. I would need to be able to choose [my doctor] because if I'm going to sign up with a doctor and have to be there for a year, and find out three months into it that this doctor is incompetent or is doing things that are going to harm my health or my daughters' health, then I'm not going to want to deal with that doctor."

"For a lot of people that's [rostering] not going to be a problem. But there'll be a few people, they look at their doctor, he looks at them and they hate each other on sight and you're stuck with him for a year, forget it. It's not going to work... it would be very damaging to the doctor/patient relationship if you didn't have flexibility."

"If you can get [patient information] onto a database and have the information on one patient transportable between [networks], moving to another [network] shouldn't be a problem... you don't need to redo all these diagnostic tests because it's all there."

"Within networks, if it's general practitioners, what are my choices in a rural area? Is it just one doctor or two? What if either one doctor's or both doctors' values don't coincide with my core values as a user, with what my needs are and what kind of active input I want into my health care? Then I'm going to want to shop around."

"If we can guarantee that there'd be a choice of more than one doctor... there has to be some sort of out. You need to be able to shop around before you make that agreement [to roster]."

Smart Cards

Most citizens agreed to the use of smart cards to improve the coordination of care and to reduce abuse. The idea is that health professionals would have access to the whole patient profile with personal health information loaded on the card or the card used to access centralized databanks.

In some dialogue sessions, smart cards were quickly accepted, but in others the privacy risks were initially thought to be too great. Citizens worry about hackers, and they are suspicious that employers, insurance companies and others will get access to the information and use it inappropriately to deny people employment or insurance coverage.

But after much weighing of the arguments, and a conversation that was both sophisticated and intense, most concluded that the benefits of smart cards outweigh the risks. One deciding factor was the conclusion that using smart cards is a better way to police misuse of the system than are user fees, which participants fear will discourage those less well off from seeking needed care. One condition specified at many dialogues for agreeing to smart cards is that only medical professionals will be able to see the file, and that the information to be recorded will be limited to what is essential for coordinating care and preventing abuse.

A Conversation on Smart Cards, in Calgary

"I think there's a lot of positive things about a smart card but there's a lot negative too because it can then become a condition of employment for people. If somebody has a chronic condition, that can be used against hiring them. How do you control that side of things?"

"One of the ideas is that this is your personal smart card... letting you dictate who you give your information to."

"But if somebody wants to use my smart card and I say no you can't, they ask – so what are you hiding?"

"I think if there's legislation that says no one can ask you for your smart card, that would solve that problem."

"There's legislation that no one can ask for your SIN number but it's on every job application that you see."

"It's [health information] all there anyway. What we need to do is re-evaluate the delivery of that information and where the security level stops. But you can't have what we want until you start cutting some of that overhead. That information has to be accessible in one place."

"Smart cards are used as a tool to identify abuse by the medical profession, not just the individual."

> ***"If I went into a hospital as an emergency, unconscious, they wouldn't know what medication I was on. I personally welcome a smart card. I want my medications on there... and my health conditions on there for my protection. The idea of a smart card in that context is to protect the patient."***

Second Opinions

Very few citizens would agree to limits on their access to second opinions. Most insisted on continued access to a second opinion outside of the network with which they are rostered, if they feel they need one. When they realized that their reluctance to forgo second opinions runs counter to their demands for greater efficiency, many resolved that tension by suggesting that people should be able to seek a second opinion outside of their network on the condition that they are willing to pay a fee for it. This is one of the few circumstances in which user payments were supported.

Limited Choice of Hospitals and Specialists

Citizens are willing to be directed to a hospital or a specialist for care, rather than choosing themselves. They are also ready to travel to get specialized care. Citizens in Regina and Quebec City, for example, argued for a concentration of resources in specialized centres of excellence for complex surgeries and medical treatments. They believe that patients and their families should be prepared to travel to major regional or even national centres in order to get the best possible care. They assume that patient travel will be covered and they acknowledge the downside of patients losing immediate access to family and friends. In this case, efficiency and excellence of service trump convenience.

Telephone Hotlines

People are willing to use telephone triage – hotlines – for information around the clock rather than automatically heading to the doctor, emergency rooms or to clinics, so long as the phone services are responsive. Many who had used hotlines were satisfied that they had avoided a doctor visit or a visit to an emergency room.

Inconvenient Times for Tests and Treatment

People agreed to go for diagnostic testing at inconvenient times late in the evenings or early in the mornings.

Smart Cards

Most citizens agreed to the use of smart cards to improve the coordination of care and to reduce abuse. The idea is that health professionals would have access to the whole patient profile with personal health information loaded on the card or the card used to access centralized databanks.

In some dialogue sessions, smart cards were quickly accepted, but in others the privacy risks were initially thought to be too great. Citizens worry about hackers, and they are suspicious that employers, insurance companies and others will get access to the information and use it inappropriately to deny people employment or insurance coverage.

But after much weighing of the arguments, and a conversation that was both sophisticated and intense, most concluded that the benefits of smart cards outweigh the risks. One deciding factor was the conclusion that using smart cards is a better way to police misuse of the system than are user fees, which participants fear will discourage those less well off from seeking needed care. One condition specified at many dialogues for agreeing to smart cards is that only medical professionals will be able to see the file, and that the information to be recorded will be limited to what is essential for coordinating care and preventing abuse.

A Conversation on Smart Cards, in Calgary

"I think there's a lot of positive things about a smart card but there's a lot negative too because it can then become a condition of employment for people. If somebody has a chronic condition, that can be used against hiring them. How do you control that side of things?"

"One of the ideas is that this is your personal smart card… letting you dictate who you give your information to."

"But if somebody wants to use my smart card and I say no you can't, they ask – so what are you hiding?"

"I think if there's legislation that says no one can ask you for your smart card, that would solve that problem."

"There's legislation that no one can ask for your SIN number but it's on every job application that you see."

"It's [health information] all there anyway. What we need to do is re-evaluate the delivery of that information and where the security level stops. But you can't have what we want until you start cutting some of that overhead. That information has to be accessible in one place."

"Smart cards are used as a tool to identify abuse by the medical profession, not just the individual."

> *"If I went into a hospital as an emergency, unconscious, they wouldn't know what medication I was on. I personally welcome a smart card. I want my medications on there... and my health conditions on there for my protection. The idea of a smart card in that context is to protect the patient."*

Second Opinions

Very few citizens would agree to limits on their access to second opinions. Most insisted on continued access to a second opinion outside of the network with which they are rostered, if they feel they need one. When they realized that their reluctance to forgo second opinions runs counter to their demands for greater efficiency, many resolved that tension by suggesting that people should be able to seek a second opinion outside of their network on the condition that they are willing to pay a fee for it. This is one of the few circumstances in which user payments were supported.

Limited Choice of Hospitals and Specialists

Citizens are willing to be directed to a hospital or a specialist for care, rather than choosing themselves. They are also ready to travel to get specialized care. Citizens in Regina and Quebec City, for example, argued for a concentration of resources in specialized centres of excellence for complex surgeries and medical treatments. They believe that patients and their families should be prepared to travel to major regional or even national centres in order to get the best possible care. They assume that patient travel will be covered and they acknowledge the downside of patients losing immediate access to family and friends. In this case, efficiency and excellence of service trump convenience.

Telephone Hotlines

People are willing to use telephone triage hotlines for information around the clock rather than automatically heading to the doctor, emergency rooms or to clinics, so long as the phone services are responsive. Many who had used hotlines were satisfied that they had avoided a doctor visit or a visit to an emergency room.

Inconvenient Times for Tests and Treatment

People agreed to go for diagnostic testing at inconvenient times late in the evenings or early in the mornings.

"I had never thought of using a hotline or seeing a nurse rather than a doctor before and now I am ready to do this." [Regina]

"I think I see a paradigm shift because I think we have agreed maybe nurse practitioners are the way to go. We don't have to see the doctor all of the time. That's a real switch. Now we just have to get the doctors to agree they don't mind losing that control." [Halifax, Day 2]

"We need great diversification in health care at the community level, more nurse practitioners, public health people, alternatives for people. There are a lot of things you don't need to go to the doctor for... we can have people who can offer this type of care for a lot less money." [Toronto]

"Give Canadians the tools they need to look after themselves, whether it's education or access to alternatives. Empower us to be responsible for our own health and I think you'll have a better system in the end." [Ottawa]

2. Increased Funding… Make It Public

Even with these changes, participants realized that more funding will be required to sustain the health care system they value. The question then becomes where to turn for the additional funding.

"How are we going to afford to do all the things we want to do with health care? We all want change. We all want more for less. How are we going to do that? Is that realistic?" [Vancouver]

"Efficiencies will only get us so much. Either we have to pay through taxes or we have to pay out of our wallets." [Regina]

"If you want the best health care, you have to pay. If we cut from here and there, it's peanuts." [Regina]

Ruling Out Private Payment

Citizens can appreciate why more privately funded and delivered services might be attractive. They spoke of their concerns about physicians leaving for the United States and they wondered whether a larger private system in Canada could stem this brain drain.

Many citizens admitted that aspects of a two-tier system exist at present people buying services in the United States and private diagnostic clinics in Canada and so questioned what would be wrong with expanding it.

Most importantly people who came with open minds about private payment were intrigued by the argument that the public system would benefit from both reduced demand and solid benchmarks due to greater competition. At some point in the day, many of these people were prepared to give others the choice of private payment if it meant a better public system with fewer demands and shorter waiting times.

A Conversation about Private Payment, in Montreal

"We discussed it in our group and [we] were opening up to the private sector insofar as a minimum guarantee of quality of equal care for everyone and guaranteed in the public system." [Translation]

"I could live with it [the private system] because I can't see that it changes anything at the level of the public system. That person, she has the means, as long as the public system guarantees me a certain basic service, then, if I have the means to shorten my pain, then I pay and I'll get quicker service ... Except that I have the means to pay, I'll pay privately and it will change nothing in the public system." [Translation]

"The woman who waits for six weeks before getting a diagnosis, even if the hospital will give it to her, the six weeks in between, I feel that's an unfair situation." [Translation]

"I have a problem when they say, yes, we need a private system because we have the means and the choice because I'm suffering. But if we arrive at a private system, that's because there's a problem with the public system. It doesn't meet our expectations, then we create a private system. Why not start by resolving our problems with the public [system] before creating another problem. It disturbs me a great deal." [Translation]

"It's inconceivable that we forbid a citizen the right to invest in his health. Yet we give him permission to invest in the health of his companion as much as he wants. I once saw on television a team of veterinarians who are equipped with scanners that are better than our hospitals. That's totally abnormal." [Translation]

"Today's topic is to see how we can develop the public system. We are all agreed that the private system exists. Our group saw it as a plus, as a luxury." [Translation]

"Do we have a right to examine the development of the private [system]? The private system is being developed, we have nothing to say about that." [Translation]

But as participants continued to work through the issues, the private parallel system came to be rejected by most. A key principle that most participants came to accept is that the

"I had never thought of using a hotline or seeing a nurse rather than a doctor before and now I am ready to do this." [Regina]

"I think I see a paradigm shift because I think we have agreed maybe nurse practitioners are the way to go. We don't have to see the doctor all of the time. That's a real switch. Now we just have to get the doctors to agree they don't mind losing that control." [Halifax, Day 2]

"We need great diversification in health care at the community level, more nurse practitioners, public health people, alternatives for people. There are a lot of things you don't need to go to the doctor for... we can have people who can offer this type of care for a lot less money." [Toronto]

"Give Canadians the tools they need to look after themselves, whether it's education or access to alternatives. Empower us to be responsible for our own health and I think you'll have a better system in the end." [Ottawa]

2. Increased Funding... Make It Public

Even with these changes, participants realized that more funding will be required to sustain the health care system they value. The question then becomes where to turn for the additional funding.

"How are we going to afford to do all the things we want to do with health care? We all want change. We all want more for less. How are we going to do that? Is that realistic?" [Vancouver]

"Efficiencies will only get us so much. Either we have to pay through taxes or we have to pay out of our wallets." [Regina]

"If you want the best health care, you have to pay. If we cut from here and there, it's peanuts." [Regina]

Ruling Out Private Payment

Citizens can appreciate why more privately funded and delivered services might be attractive. They spoke of their concerns about physicians leaving for the United States and they wondered whether a larger private system in Canada could stem this brain drain.

Many citizens admitted that aspects of a two-tier system exist at present – people buying services in the United States and private diagnostic clinics in Canada – and so questioned what would be wrong with expanding it.

Most importantly people who came with open minds about private payment were intrigued by the argument that the public system would benefit from both reduced demand and solid benchmarks due to greater competition. At some point in the day, many of these people were prepared to give others the choice of private payment if it meant a better public system with fewer demands and shorter waiting times.

A Conversation about Private Payment, in Montreal

"We discussed it in our group and [we] were opening up to the private sector insofar as a minimum guarantee of quality of equal care for everyone and guaranteed in the public system." [Translation]

"I could live with it [the private system] because I can't see that it changes anything at the level of the public system. That person, she has the means, as long as the public system guarantees me a certain basic service, then, if I have the means to shorten my pain, then I pay and I'll get quicker service. ... Except that I have the means to pay, I'll pay privately and it will change nothing in the public system." [Translation]

"The woman who waits for six weeks before getting a diagnosis, even if the hospital will give it to her, the six weeks in between, I feel that's an unfair situation." [Translation].

"I have a problem when they say, yes, we need a private system because we have the means and the choice because I'm suffering. But if we arrive at a private system, that's because there's a problem with the public system. It doesn't meet our expectations, then we create a private system. Why not start by resolving our problems with the public [system] before creating another problem. It disturbs me a great deal." [Translation]

"It's inconceivable that we forbid a citizen the right to invest in his health. Yet we give him permission to invest in the health of his companion as much as he wants. I once saw on television a team of veterinarians who are equipped with scanners that are better than our hospitals. That's totally abnormal." [Translation]

"Today's topic is to see how we can develop the public system. We are all agreed that the private system exists. Our group saw it as a plus, as a luxury." [Translation]

"Do we have a right to examine the development of the private [system]? The private system is being developed, we have nothing to say about that." [Translation]

But as participants continued to work through the issues, the private parallel system came to be rejected by most. A key principle that most participants came to accept is that the only way such a scenario would be acceptable is if it did not harm the public system. By the end of the dialogue, this scenario was rejected by citizens who concluded it cannot meet that test, and would drain valuable resources away from the public system. This conclusion was often reinforced by participants with direct experience of public systems in countries such as the United Kingdom, New Zealand and the United States, which encourage private payment for private care, as well as by distaste for the rich being able to jump the queue. But the key consideration in the end was the determination not to harm the public system.

"Why take away my choice about where to get services?" [Regina]

"I think we should be able to buy insurance and should be able to use it in a private clinic and it's wrong for anyone to say otherwise." [Ottawa]

"Talking to all the people in our group and listening to comments here, I've definitely changed some of my thinking. I still feel that there's room, not necessarily for a two-tier system, but more involvement from the private sector just to help from the financial aspect and it gives me a few more choices." [Vancouver]

"Public systems have a tendency to build bureaucracies. Private systems can't afford that. So [two-tier] may actually point out inefficiencies in the public system." [Vancouver]

"I really believed that the two-tier system was worth exploring but I decided against it as the day went on. ... do not want my health to be at the expense of other Canadians." [Ottawa]

"With a two-tier system, the issue on the table would be that people [would] bypass the waiting list and take away the opportunity for other people to have surgery that they require. It would just compound the problem we have now with waiting lists." [Vancouver]

"I'm very fearful of that [two-tiers] and concerned. What doctors will be left to provide public care if there was a private sector that doctors could be employed by?... I'd rather fix what we have, rather than open that door." [Halifax, Day 1]

"Two-tier health care is ideal. But the practical reality is as people get pulled out of the queue for the public system and once that pressure is relieved, the government... is going to say, 'we can save some money here.' That means we're going to have a public system like the public system in the US where 40 percent of the population has zero percent health care." [Ottawa]

"I'm in my seventh decade of life. Two decades ago, I would have been with my [younger] friend in front of me. But now I'm totally opposed to privatization. My thinking is that would be discriminatory to all people with less income. I still feel that way. I felt that way when I came." [Regina]

Saying "No" and Maybe "Yes" to Copayments

Citizens wrestled with the idea of copayments. Most were convinced that fees should not be charged for basic services such as seeing the family doctor, a specialist or staying overnight in a hospital, and believed it would discourage those who are less well off from seeking needed care. Even with assurances that fees would be capped, and that low-income patients would be subsidized, this resistance remained. The fact that fees would be capped leads some citizens to speculate that they will generate only modest revenue, so why bother? They also suggested that the cost of administering such a system will eat up much of the revenue.

"I came in here thinking user fees were a terrible thing. I guess seeing how Sweden and other countries use them where there is a cap and it's not a punishment for people who are sick chronically. I can see how that could be of use in our system." *[Halifax, Day 1]*

"There's been research that has shown the people who make the least money have the worst health. If you're going to charge them, which leaves them with less money, they will have a worsening condition of health and they won't be able to get their new services. So co-pay won't work unless there are some really stringent balances; who has to pay, what level of income should you be at before you pay." *[Halifax, Day 2]*

We are against copayments, especially for the mentally challenged." [Translation] [Québec]

"If it's a $5 user fee, are we going to spend $3.85 to get that $5 through the system? I don't think it can work." [Vancouver]

"My opinion has changed slightly with regard to Scenario 4, as far as a second opinion, the possibility of paying for that opinion, why not? [*Translation*] *[Bathurst]*

The most attractive argument to citizens for using copayments was that they will deter misuse and abuse of health care services. But, once participants arrived at the conclusion that smart cards provide an alternative way to track use and abuse, they set aside using copayments for these purposes.

In the end, the door was left open to having user fees for certain specified extra services only (for example, a second opinion provided by a physician outside of a rostered system).

only way such a scenario would be acceptable is if it did not harm the public system. By the end of the dialogue, this scenario was rejected by citizens who concluded it cannot meet that test, and would drain valuable resources away from the public system. This conclusion was often reinforced by participants with direct experience of public systems in countries such as the United Kingdom, New Zealand and the United States, which encourage private payment for private care, as well as by distaste for the rich being able to jump the queue. But the key consideration in the end was the determination not to harm the public system.

"Why take away my choice about where to get services?" [Regina]

"I think we should be able to buy insurance and should be able to use it in a private clinic and it's wrong for anyone to say otherwise." [Ottawa]

"Talking to all the people in our group and listening to comments here, I've definitely changed some of my thinking. I still feel that there's room, not necessarily for a two-tier system, but more involvement from the private sector just to help from the financial aspect and it gives me a few more choices." [Vancouver]

"Public systems have a tendency to build bureaucracies. Private systems can't afford that. So [two-tier] may actually point out inefficiencies in the public system." [Vancouver]

"I really believed that the two-tier system was worth exploring but I decided against it as the day went on. ... do not want my health to be at the expense of other Canadians." [Ottawa]

"With a two-tier system, the issue on the table would be that people [would] bypass the waiting list and take away the opportunity for other people to have surgery that they require. It would just compound the problem we have now with waiting lists." [Vancouver]

"I'm very fearful of that [two-tiers] and concerned. What doctors will be left to provide public care if there was a private sector that doctors could be employed by? ... I'd rather fix what we have, rather than open that door." [Halifax, Day 1]

"Two-tier health care is ideal. But the practical reality is as people get pulled out of the queue for the public system and once that pressure is relieved, the government... is going to say, 'we can save some money here.' That means we're going to have a public system like the public system in the US where 40 percent of the population has zero percent health care." [Ottawa]

"I'm in my seventh decade of life. Two decades ago, I would have been with my [younger] friend in front of me. But now I'm totally opposed to privatization. My thinking is that would be discriminatory to all people with less income. I still feel that way. I felt that way when I came." [Regina]

Saying "No" and Maybe "Yes" to Copayments

Citizens wrestled with the idea of copayments. Most were convinced that fees should not be charged for basic services such as seeing the family doctor, a specialist or staying overnight in a hospital, and believed it would discourage those who are less well off from seeking needed care. Even with assurances that fees would be capped, and that low-income patients would be subsidized, this resistance remained. The fact that fees would be capped leads some citizens to speculate that they will generate only modest revenue, so why bother? They also suggested that the cost of administering such a system will eat up much of the revenue.

> *"I came in here thinking user fees were a terrible thing. I guess seeing how Sweden and other countries use them where there is a cap and it's not a punishment for people who are sick chronically, I can see how that could be of use in our system."*
> *[Halifax, Day 1]*
>
> *"There's been research that has shown the people who make the least money have the worst health. If you're going to charge them, which leaves them with less money, they will have a worsening condition of health and they won't be able to get their new services. So co-pay won't work unless there are some really stringent balances, who has to pay, what level of income should you be at before you pay."*
> *[Halifax, Day 2]*
>
> *We are against copayments, especially for the mentally challenged." [Translation]*
> *[Québec]*
>
> *"If it's a $5 user fee, are we going to spend $3.85 to get that $5 through the system? I don't think it can work." [Vancouver]*
>
> *"My opinion has changed slightly with regard to Scenario 4, as far as a second opinion, the possibility of paying for that opinion, why not?" [Translation]*
> *[Bathurst]*

The most attractive argument to citizens for using copayments was that they will deter misuse and abuse of health care services. But, once participants arrived at the conclusion that smart cards provide an alternative way to track use and abuse, they set aside using copayments for these purposes.

In the end, the door was left open to having user fees for certain specified extra services only (for example, a second opinion provided by a physician outside of a rostered system).

Putting Taxes into Health Care

Citizens then turned to public funding, and first hoped that transfers of funds from other government programs could be used to add resources to health care.

> *"Some very big choices need to be made. Some sacrifices need to be made and it's unfortunate that we all want more but I don't' mind making the sacrifice. If I have to pay more, so be it. I would prefer not the tax increase; I would prefer the reallocation of funds… it doesn't bother me that our peacekeepers are wearing green when they should be wearing tan… I just think there are some things that aren't as important as health care and I'm all in favour of reallocating those funds to health care. [Vancouver]*
>
> *My views have evolved … I think from listening to other people, that methods of reallocation [exist], whether you take money out of the military or you take money out of bureaucracy. It became very clear that education is not one of them, not to take it out of but to add to, as in preventive medicine." [Vancouver]*
>
> *"I've noticed that cost sharing is important between citizens and the governments, and then there are many solutions that we can bring. But one solution that I don't want to see brought forward is that we cut on education. I think it's important to make all citizens aware of their responsibilities in order to lower costs." [Translation] [Montréal, Day 2]*

But when citizens were pressed to say which expenditures should be cut to make room for health care, that hope evaporated as they eliminated the candidates one by one. Most firmly opposed taking money out of education and social programs. When the facilitators pointed out that these are the largest components of provincial expenditure, next to health care, citizens searched wider and deeper for alternatives. While many provincial and federal programs were named, there was no agreement on what should be cut. There was a consensus that bureaucratic processes and procedures waste and red tape across departments must be eliminated, but also a realization that this alone will not yield the funds required.

> *"Even as a low-income student, I would be willing to pay more tax and I've never said that before in my life." [Calgary]*
>
> *"I think the perception, mostly in the media, is that we don't care about publicly funded health care. It's good to see that's probably not the case." [Calgary]*
>
> *"The most important insight I had today was that people are willing to pay more [taxes] for the system and that surprised me." [Ottawa]*
>
> *"Yes, I would be prepared to pay a little more but on the condition that I know now that the tax dollars I pay out, I would know where they are spent and that they are spent advisedly. Knowing that, perhaps I would be able to pay more."[Translation] [Québec City]*
>
> *"I got the impression that the majority of those who presented scenarios were more in favour of reoganizing the existing resources, rather than increasing the existing resources." [Translation] [Montréal, Day 2]*
>
> *"We said that later, once it's well organized, the costs will be lowered and well managed, then we can talk about additional costs. But for the time being, there is too much waste." [Translation] [Montréal, Day 2]*

One form of "reallocation" surfaced often, but not always. Many citizens wished to see a greater federal financial contribution to health care, and they saw the current federal surplus as the logical source. Eventually, however, all the sessions came to realize that sooner or later, new money would be required to make the system sustainable. They were left with tax increases as the only viable choice.

At the same time citizens placed very stringent conditions on their support for any tax increase. They insisted on stronger accountability from users, providers, governments, and other players in the health care system. But at the end of the day, citizens came to the conclusion that taxes are consistent with their notion of solidarity — that health care is a public good to be financed by public means.

Putting Taxes into Health Care

Citizens then turned to public funding, and first hoped that transfers of funds from other government programs could be used to add resources to health care.

"Some very big choices need to be made. Some sacrifices need to be made and it's unfortunate that we all want more but I don't' mind making the sacrifice. If I have to pay more, so be it. I would prefer not the tax increase; I would prefer the reallocation of funds... it doesn't bother me that our peacekeepers are wearing green when they should be wearing tan... I just think there are some things that aren't as important as health care and I'm all in favour of reallocating those funds to health care. [Vancouver]

My views have evolved ... I think from listening to other people, that methods of reallocation [exist], whether you take money out of the military or you take money out of bureaucracy. It became very clear that education is not one of them, not to take it out of but to add to, as in preventive medicine." [Vancouver]

"I've noticed that cost sharing is important between citizens and the governments, and then there are many solutions that we can bring. But one solution that I don't want to see brought forward is that we cut on education. I think it's important to make all citizens aware of their responsibilities in order to lower costs." [Translation] [Montréal, Day 2]

But when citizens were pressed to say which expenditures should be cut to make room for health care, that hope evaporated as they eliminated the candidates one by one. Most firmly opposed taking money out of education and social programs. When the facilitators pointed out that these are the largest components of provincial expenditure, next to health care, citizens searched wider and deeper for alternatives. While many provincial and federal programs were named, there was no agreement on what should be cut. There was a consensus that bureaucratic processes and procedures – waste and red tape – across departments must be eliminated, but also a realization that this alone will not yield the funds required.

"Even as a low-income student, I would be willing to pay more tax and I've never said that before in my life." [Calgary]

"I think the perception, mostly in the media, is that we don't care about publicly funded health care. It's good to see that's probably not the case." [Calgary]

"The most important insight I had today was that people are willing to pay more [taxes] for the system and that surprised me." [Ottawa]

"Yes, I would be prepared to pay a little more but on the condition that I know now that the tax dollars I pay out, I would know where they are spent and that they are spent advisedly. Knowing that, perhaps I would be able to pay more."[Translation] [Québec City]

"I got the impression that the majority of those who presented scenarios were more in favour of reoganizing the existing resources, rather than increasing the existing resources." [Translation] [Montréal, Day 2]

"We said that later, once it's well organized, the costs will be lowered and well managed, then we can talk about additional costs. But for the time being, there is too much waste." [Translation] [Montréal, Day 2]

One form of "reallocation" surfaced often, but not always. Many citizens wished to see a greater federal financial contribution to health care, and they saw the current federal surplus as the logical source. Eventually, however, all the sessions came to realize that sooner or later, new money would be required to make the system sustainable. They were left with tax increases as the only viable choice.

At the same time citizens placed very stringent conditions on their support for any tax increase. They insisted on stronger accountability from users, providers, governments, and other players in the health care system. But at the end of the day, citizens came to the conclusion that taxes are consistent with their notion of solidarity – that health care is a public good to be financed by public means.

3. Stronger Accountability and Transparency

Across the country, there were sustained and stinging attacks on how health care systems in Canada are managed from the grassroots of primary care to the highest political offices in the land. The message is "we are spending $100 billion already; we have to get our act together."

> *"We must and we can do better with what we already have. Everyone agreed that management is the health care system's main challenge there must be a thorough house cleaning before anything else is done." [Translation] [Québec]*

If they are going to pay even more taxes, citizens demand more rigorous accountability by all players in the system.

Providers

Most citizens expressed appreciation for their relationship with their own doctor, and some came to the dialogue having spoken to their doctor about the health care system. They brought their doctor's perspective to share with others. They also frequently expressed sympathy for the difficulties that their own doctor and others face in running a practice under the current system.

But their trust of their own doctor did not prevent citizens from leveling criticisms at doctors and other providers, and insisting that providers, too, need to become more accountable.

As they worked through the choices and trade-offs, citizens questionned the incentives in the current fee-for-service system. They cited occasions where doctors book follow-up appointments too often or too soon, as well as media reports of billing fraud.

> *"Why pay more taxes when there's [billing] fraud?" [Toronto]*

They concluded that alternative methods of physician remuneration should be explored as one element of primary care reform, in order to de-link physician income from numbers of visits. Acknowledging that physicians are currently accountable to their professional colleges, citizens nevertheless called for more public accountability for the use of public resources.

While they can see that independent practitioners prefer to make decisions based on their own findings, they criticized the duplication of effort required when each one does his own assessment, keeps her own records and orders another set of diagnostics. Through the multi-disciplinary team approach, they expect professionals to share, critique and use

3. Stronger Accountability and Transparency

Across the country, there were sustained and stinging attacks on how health care systems in Canada are managed – from the grassroots of primary care to the highest political offices in the land. The message is "we are spending $100 billion already; we have to get our act together."

> *"We must and we can do better with what we already have. Everyone agreed that management is the health care system's main challenge – there must be a thorough house cleaning before anything else is done." [Translation] [Québec]*

If they are going to pay even more taxes, citizens demand more rigorous accountability by all players in the system.

Providers

Most citizens expressed appreciation for their relationship with their own doctor, and some came to the dialogue having spoken to their doctor about the health care system. They brought their doctor's perspective to share with others. They also frequently expressed sympathy for the difficulties that their own doctor and others face in running a practice under the current system.

But their trust of their own doctor did not prevent citizens from leveling criticisms at doctors and other providers, and insisting that providers, too, need to become more accountable.

As they worked through the choices and trade-offs, citizens questionned the incentives in the current fee-for-service system. They cited occasions where doctors book follow-up appointments too often or too soon, as well as media reports of billing fraud.

> *"Why pay more taxes when there's [billing] fraud?" [Toronto]*

They concluded that alternative methods of physician remuneration should be explored as one element of primary care reform, in order to de-link physician income from numbers of visits. Acknowledging that physicians are currently accountable to their professional colleges, citizens nevertheless called for more public accountability for the use of public resources.

While they can see that independent practitioners prefer to make decisions based on their own findings, they criticized the duplication of effort required when each one does his own assessment, keeps her own records and orders another set of diagnostics. Through the multi-disciplinary team approach, they expect professionals to share, critique and use

62

each other's findings. To maximize the efficiency gains of adopting smart cards, they expect physicians to be willing to share data and information.

Citizens criticized doctors who leave the country without "paying back" the public investment in their education. They suggest that in these instances doctors should be required to reimburse government a portion of their education costs.

Citizens were also suspicious of the pharmaceutical industry's influence on the medical profession. Citizens felt that physicians are giving in to pressures from drug companies to prescribe the latest most expensive products, which may deliver only marginally greater benefits, if any, than older less expensive drugs. They called for greater transparency in the relationships between doctors and drug companies.

Drug Companies

Citizens were acutely aware of the benefits of prescription medications to their health and to the health care system, but they struggled with how drug costs are challenging both the affordability of the health care system and the pocketbooks of individuals and families with limited means. With drugs becoming increasingly expensive, they take funds away from other priorities. People are willing to change their expectations for the sake of affordability and accept generic equivalents. As with advanced medical technology more generally, citizens are looking for evidence of benefit to cost relative to existing drugs. And they are also demanding stronger, clearer accountabilities in this area.

Citizens were critical of the Canadian patent legislation that extended protection of brand name products, delaying their access to generic equivalents. They acknowledged that research and development costs are high, but they are suspicious of how much of this activity is truly occurring in Canada. They want drug companies to be more transparent about the types and extent of their research and development activities in Canada.

The process by which new products are accepted into publicly covered systems and how prices are set is opaque. By extension, the participants questioned the provisions of trade agreements that require brand name protection at the expense of the domestic health care system and, ultimately, the citizen. This led them to express support for more government interventions as a counterweight to the power of the industry, and more transparency overall in how these decisions are made.

"Corporate responsibility shouldn't end with keeping a healthy work environment. I think pharmaceutical companies should give some of the money they're making back to the health care system." [Thunder Bay]

"We need to look at the issue of prescription drugs at the broader level of drug companies' accountability – the role that they play in the development of drug patent laws. They are the beneficiaries of that. So I think the federal government has to be involved at that level as well." [Toronto]

"If a pharmaceutical company comes out with a new drug that is five percent better but costs three times as much, the public might want to know about that. If that kind of knowledge was made available to the public, it might have some impact on the choices people make. It's an attitude change. I think patients can be more accountable. Do I really need the more expensive medication, the more expensive device?" [Ottawa]

Participants also expressed support for a greater emphasis on non-drug based therapies, in part to counter the marketing practices of drug companies, which promote the idea that drugs are the surest solution to any health problem. Citizens argued, for example, that diet can control some health problems as well as or better than drugs, and that palliative care is often a more compassionate choice than heroic treatment at the end of life.

Industries That Threaten Health

Some citizens felt very strongly that industries that are responsible for a proven negative impact on the health of a community should be prosecuted and severely fined, with proceeds to be directed to health care. Environment polluters were often the examples used. Others added that industries whose products or services threaten health should be taxed at higher rates than the norm. But some argued that levying higher corporate taxes would only result in them being passed on to consumers. And they felt that corporations make significant economic contributions through employment and extended health care coverage already. Nonetheless, a strong feeling remained that industries that make their profits in ways that increase health problems should be held to account.

"The majority of people don't understand the nature of illness has changed. It's degenerative now as opposed to infectious diseases as it was 100 years ago. We have to address that. It's because we deliberately poison our environment and food supply. If we don't address that, there's not much point in continuing to empty lots of money into drugs and treatments we have now." [Halifax, Day 1]

"People are expected to work twice the number of hours they used to... especially here in Ottawa in high tech. They're expected to work all week, at the weekends as well. They're burnt out, they get sick and maybe companies should be held responsible for this." [Ottawa]

"Put more taxes on tobacco, alcohol, on companies that do harm. Even car companies, they add to the pollution, take away from our quality of life and ultimately from our health." [Vancouver]

The Media

Citizens appeared surprised that they did not encounter more conflict in the dialogue session. Many expressed surprise and relief that so many of their colleagues expressed the same values as their own. From media reports they had assumed that the views of citizens would be far more polarized than they turned out to be. Instead, they found that they agreed with each other on perhaps 80 percent of matters, and, in that context, talking about the remaining 20 percent was far easier. By contrast the image they had received from the media focused on the 20 percent where views differed, and further magnified that difference by seeking out the most committed and uncompromising spokespersons for the different points of view. Participants went on to call for greater accountability on the part of the media, to report more balanced perspectives on how the health care system is performing and what citizens are saying.

Local authorities and administrators

Citizens observe rivalries among hospitals, health centres, and cities that lead to duplication of service and inefficient scale of operations. Despite all the health care restructuring and talk of reform over the 1990s, most citizens have not experienced improvements in their day-to-day interaction with the system. They believe that waiting times are increasing for all types of care – medical appointments, diagnostics and treatment, especially surgery.

People want administrators and local health authorities to account for how their efforts make the system better. Citizens spoke of wanting system-wide and local performance to be measured against preset goals or benchmarks. Ongoing evaluation should include comparisons to other facilities and regions. They want their local representatives to disclose how various decisions are made – who is involved and what information is used.

"Corporate responsibility shouldn't end with keeping a healthy work environment. I think pharmaceutical companies should give some of the money they're making back to the health care system." [Thunder Bay]

"We need to look at the issue of prescription drugs at the broader level of drug companies' accountability – the role that they play in the development of drug patent laws. They are the beneficiaries of that. So I think the federal government has to be involved at that level as well." [Toronto]

"If a pharmaceutical company comes out with a new drug that is five percent better but costs three times as much, the public might want to know about that. If that kind of knowledge was made available to the public, it might have some impact on the choices people make. It's an attitude change. I think patients can be more accountable. Do I really need the more expensive medication, the more expensive device?" [Ottawa]

Participants also expressed support for a greater emphasis on non-drug based therapies, in part to counter the marketing practices of drug companies, which promote the idea that drugs are the surest solution to any health problem. Citizens argued, for example, that diet can control some health problems as well as or better than drugs, and that palliative care is often a more compassionate choice than heroic treatment at the end of life.

Industries That Threaten Health

Some citizens felt very strongly that industries that are responsible for a proven negative impact on the health of a community should be prosecuted and severely fined, with proceeds to be directed to health care. Environment polluters were often the examples used. Others added that industries whose products or services threaten health should be taxed at higher rates than the norm. But some argued that levying higher corporate taxes would only result in them being passed on to consumers. And they felt that corporations make significant economic contributions through employment and extended health care coverage already. Nonetheless, a strong feeling remained that industries that make their profits in ways that increase health problems should be held to account.

> *"The majority of people don't understand the nature of illness has changed. It's degenerative now as opposed to infectious diseases as it was 100 years ago. We have to address that. It's because we deliberately poison our environment and food supply. If we don't address that, there's not much point in continuing to empty lots of money into drugs and treatments we have now." [Halifax, Day 1]*
>
> *"People are expected to work twice the number of hours they used to... especially here in Ottawa in high tech. They're expected to work all week, at the weekends as well. They're burnt out, they get sick and maybe companies should be held responsible for this." [Ottawa]*
>
> *"Put more taxes on tobacco, alcohol, on companies that do harm. Even car companies, they add to the pollution, take away from our quality of life and ultimately from our health." [Vancouver]*

The Media

Citizens appeared surprised that they did not encounter more conflict in the dialogue session. Many expressed surprise and relief that so many of their colleagues expressed the same values as their own. From media reports they had assumed that the views of citizens would be far more polarized than they turned out to be. Instead, they found that they agreed with each other on perhaps 80 percent of matters, and, in that context, talking about the remaining 20 percent was far easier. By contrast the image they had received from the media focused on the 20 percent where views differed, and further magnified that difference by seeking out the most committed and uncompromising spokespersons for the different points of view. Participants went on to call for greater accountability on the part of the media, to report more balanced perspectives on how the health care system is performing and what citizens are saying.

Local authorities and administrators

Citizens observe rivalries among hospitals, health centres, and cities that lead to duplication of service and inefficient scale of operations. Despite all the health care restructuring and talk of reform over the 1990s, most citizens have not experienced improvements in their day-to-day interaction with the system. They believe that waiting times are increasing for all types of care — medical appointments, diagnostics and treatment, especially surgery.

People want administrators and local health authorities to account for how their efforts make the system better. Citizens spoke of wanting system-wide and local performance to be measured against preset goals or benchmarks. Ongoing evaluation should include comparisons to other facilities and regions. They want their local representatives to disclose how various decisions are made — who is involved and what information is used.

Citizens were cautious and unclear about how much control should reside at the local level. Views on this varied as did current circumstances across the country. Many felt that more centralization is needed to improve accountability – fewer levels and players. Others countered that some major infrastructure decisions should be made by the province, but insisted that regional and local institutions, closer to the people, should be responsible and held accountable for allocating some of the total envelope of resources to meet local needs. Most agreed that responsibilities need to be clarified and duplication reduced. Citizens want to know more clearly who is accountable for what and what kind of job they are doing.

A Conversation about Accountability, in Vancouver

"Give us a thermometer with which we can take [the health care system's] temperature and keep doing it every year. We want to know."

"Create measures of performance for health care providers that we don't use now. You can have national measures, regional measures, local measures... but you have to determine what kind of system you have before you hold it accountable because you'll have to have measurable objectives."

"I'm not in favour of monitoring or evaluating the system if it's just for the sake of evaluating where we're at. As long as we use the information to make the system better, then I'm in favour of it. But it it's just an audit for the sake of auditing, that's where your redundancy and your costs come... I want the information to make a better system."

Governments and Policymakers

While the Dialogue Project was not designed to support a discussion of federal-provincial relationships and responsibilities, citizens across Canada expressed frustration and even outrage at the ongoing battles between federal and provincial governments. They find the different jurisdictions confusing and unclear, making it impossible for them as citizens to know who to hold accountable for what. They see the political battles as delaying necessary decisions, and precipitating deterioration in the quality of service. They believe that politicians are distracted by their own positioning and have lost sight of the needs of citizens. Many citizens complained about the layers of bureaucracy – federal, provincial, regional and local levels, each with its own administration, creating duplication and wasting resources.

"What was missing for me was a question of leadership or an architect. Do we have an architect or a bunch of mechanics who are all working on different parts of some sort of machine?" [Montreal, Day 1]

"Public cynicism stems from the lack of accountability." [Toronto]

"My message is [to] the federal and provincial governments... I'm tired of the politics and rhetoric. Get together for the good of the people." [Calgary]

Despite all efforts to exclude constitutional issues, at a number of sessions strong minorities advocated transferring responsibility for health care from provinces to the federal government. This seemed to be based mostly on a desire to bring greater clarity to the management of the system, to have a single authority they could hold to account. In other regions, people asked for a third-party arm's-length agency at the national level to oversee the health care system, as a way to depoliticize it.

Most dialogues independently came up with the suggestion that an independent auditor general for health care should be established to provide unbiased reports on how the health care system is performing in different jurisdictions, how that is changing, and whether taxpayers are getting value for money. Many also called for a national-level patient ombudsman to be established to publicize citizens' experiences and to publicly advocate on their behalf.

In many sessions, citizens called on the federal government to pay a greater share of the overall costs of health care. The federal government is seen as both a source of funding and an overall guardian for the system, ensuring that coverage and access are reasonably comparable across the country.

"(We) need human resources – an increase from the federal (of) 50 percent, from the provincial (of) 50 percent." [Translation] [Bathurst]

"I don't understand why it has to be provincial/federal. Why can't we revamp it to be one or the other? That way we don't have to worry, we know it will all be spent on health. Why can't the federal government pay the whole thing and our health tax go to that?" [Halifax, Day 2]

"We recommend that the federal government put more money in. If the feds stop paying a significant share then it will have less say in what the health care system should look like. We can recommend the increased public investment we have all agreed on come from the federal government." [Thunder Bay]

"What we're hearing here today on balance flies in the face of what provincial premiers across the country are espousing, that the federal government's influence be diminished. What I heard today is that the federal government has a larger and more important role to play and better get on with playing it." [Toronto]

Citizens were cautious and unclear about how much control should reside at the local level. Views on this varied as did current circumstances across the country. Many felt that more centralization is needed to improve accountability – fewer levels and players. Others countered that some major infrastructure decisions should be made by the province, but insisted that regional and local institutions, closer to the people, should be responsible and held accountable for allocating some of the total envelope of resources to meet local needs. Most agreed that responsibilities need to be clarified and duplication reduced. Citizens want to know more clearly who is accountable for what and what kind of job they are doing.

A Conversation about Accountability, in Vancouver

"Give us a thermometer with which we can take [the health care system's] temperature and keep doing it every year. We want to know."

"Create measures of performance for health care providers that we don't use now. You can have national measures, regional measures, local measures... but you have to determine what kind of system you have before you hold it accountable because you'll have to have measurable objectives."

"I'm not in favour of monitoring or evaluating the system if it's just for the sake of evaluating where we're at. As long as we use the information to make the system better, then I'm in favour of it. But it it's just an audit for the sake of auditing, that's where your redundancy and your costs come... I want the information to make a better system."

Governments and Policymakers

While the Dialogue Project was not designed to support a discussion of federal-provincial relationships and responsibilities, citizens across Canada expressed frustration and even outrage at the ongoing battles between federal and provincial governments. They find the different jurisdictions confusing and unclear, making it impossible for them as citizens to know who to hold accountable for what. They see the political battles as delaying necessary decisions, and precipitating deterioration in the quality of service. They believe that politicians are distracted by their own positioning and have lost sight of the needs of citizens. Many citizens complained about the layers of bureaucracy – federal, provincial, regional and local levels, each with its own administration, creating duplication and wasting resources.

"What was missing for me was a question of leadership or an architect. Do we have an architect or a bunch of mechanics who are all working on different parts of some sort of machine?" [Montreal, Day 1]

"Public cynicism stems from the lack of accountability." [Toronto]

"My message is [to] the federal and provincial governments... I'm tired of the politics and rhetoric. Get together for the good of the people." [Calgary]

Despite all efforts to exclude constitutional issues, at a number of sessions strong minorities advocated transferring responsibility for health care from provinces to the federal government. This seemed to be based mostly on a desire to bring greater clarity to the management of the system, to have a single authority they could hold to account. In other regions, people asked for a third-party arm's-length agency at the national level to oversee the health care system, as a way to depoliticize it.

Most dialogues independently came up with the suggestion that an independent auditor general for health care should be established to provide unbiased reports on how the health care system is performing in different jurisdictions, how that is changing, and whether taxpayers are getting value for money. Many also called for a national-level patient ombudsman to be established to publicize citizens' experiences and to publicly advocate on their behalf.

In many sessions, citizens called on the federal government to pay a greater share of the overall costs of health care. The federal government is seen as both a source of funding and an overall guardian for the system, ensuring that coverage and access are reasonably comparable across the country.

"(We) need human resources – an increase from the federal (of) 50 percent, from the provincial (of) 50 percent." [Translation] [Bathurst]

"I don't understand why it has to be provincial/federal. Why can't we revamp it to be one or the other? That way we don't have to worry, we know it will all be spent on health. Why can't the federal government pay the whole thing and our health tax go to that?" [Halifax, Day 2]

"We recommend that the federal government put more money in. If the feds stop paying a significant share then it will have less say in what the health care system should look like. We can recommend the increased public investment we have all agreed on come from the federal government." [Thunder Bay]

"What we're hearing here today on balance flies in the face of what provincial premiers across the country are espousing, that the federal government's influence be diminished. What I heard today is that the federal government has a larger and more important role to play and better get on with playing it." [Toronto]

By the end of the day, after working through all of these issues, citizens across the country were clear and remarkably consistent in the improvements they wanted to see from governments in the management of the system:

- *Greater transparency.* Citizens want to know where the money is going. They want to see regular reports for their region and jurisdiction that show how the system is being used and how the money is spent.

- *Earmark taxes for health care.* To further increase transparency, citizens want to be sure that any additional taxes for health care will be spent on health care.

- *Create an auditor general for health.* Citizens want documentation of value for money, and of how their jurisdiction is doing in relation to its past performance and to other jurisdictions. They believe that this information should come from an independent agency, such as an auditor general for health with an overall purview of the state of Medicare.

- *Greater efficiency and co-operation within and among governments.* Citizens are:

    - fed up with federal-provincial disputes, which they see as adding cost and delaying decisions without improving the services they receive. They want to know more clearly who is responsible for what so that they can be held to account.

    - aware of the connection between health and other governmental responsibilities such as the environment, social programs, and housing. They want joint interdepartmental strategies to address the determinants of health.

    - demanding greater efficiency generally. For example, they believe that when regional institutions are created, provincial ministries should be reduced in size, and that politicians and ministries should not second-guess decisions at the regional and local levels. Overall, they want to see duplication reduced, and responsibilities and accountabilities spelled out more clearly.

- *Establish a national ombudsman.* Some citizens would like to have a national patient ombudsman, acting as an advocate on their behalf.

4. Citizens' Judgment on Health Reform

In summary, a logic model emerged in the afternoon. The exact sequence varied from session to session, but the outcome was the same each time, with citizens saying:

- First, secure efficiency gains through reforms consistent with the values of access, fairness and efficiency. This includes the primary care reforms in scenario 4, and requires changes in the behaviour of citizens, providers and governments. Citizens are prepared to sign up with a team of professionals for at least one year, see a nurse for routine care, make greater use of new technologies and opt for an electronic health card.
- Second, introduce stronger accountability, to show clearly where money goes and what actions are adding value.
- Third, increase funding through higher taxes (scenario 1) rather than accept cuts to education and social spending.
- Fourth, there are some situations where copayment or user fees would be appropriate (Scenario 2), but not for basic medical services.
- Fifth, a parallel private system (Scenario 3) is not acceptable because it would drain valuable resources away from the public system.

Citizens' judgment on health care reform and the new contract can be paraphrased as follows:

> *We citizens place a high value on equal access and universal coverage. We see health care as a public resource for all citizens. Therefore, we will help to create a sustainable health care system, on condition that governments and providers commit to three conditions: more efficient management and service delivery, more coordinated and patient-centred care, and greater transparency and accountability in how they spend health care dollars.*
>
> *With progress on these commitments, we are prepared to change our own behaviour to promote wellness, make certain sacrifices in the way we access the system, and to pay more. In paying more, our first choice is to pay through taxes earmarked for health care, so that basic services are financed through more public investment. As a backup, we will accept copayments or user fees, but only for a limited number of additional services. On balance, we do not support the creation of a parallel private system.*

VI Confirming the Choices

Final Views of the Four Scenarios

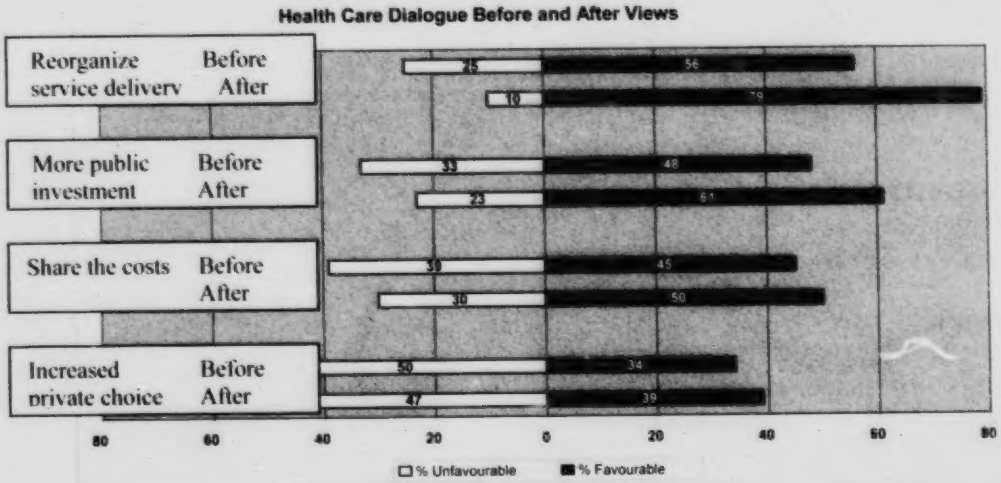
At about 4:30 in the afternoon, as the dialogue session drew to a close, participants completed the same questionnaire that they had first filled in earlier in the day.

After a day of weighing both the pros and cons of all scenarios, listening and learning from fellow citizens, many had adjusted their "coming in" stereotypes and could now recognize the merits and possibilities in potential approaches to reform that they originally did not like. In scoring the scenarios now, citizens were encouraged to attach conditions in order to be more explicit about their expectations.

Their responses to the scenarios reveal a much greater openness to change than there had been at the beginning of the day. Indeed all four scenarios were seen in a more favourable light, although to greatly differing degrees. This increase in support for all four scenarios happened as views crystallized and resulted from at least three factors:

- First, the number of people who were undecided diminished;
- Second, as the understanding of the need for reform grew throughout the day, support for the status quo dropped. This produced an increase in support for all four scenarios (although the amount of increase for each varied substantially), since all four include elements of reform; and
- Third, citizens were asked to rate all four options, not to choose one. And in fact they forged a complex synthesis, integrating elements of three of the four scenarios.

Figure 7



Note: Citizens used a 7-point scale to respond to the scenarios. Scores of 5-7 were favourable; 1-3 were unfavourable. An answer of 4 was undecided.
Source: Citizens' Dialogue on the Future of Health Care in Canada.

Figure 7 shows a dramatic shift in views over the course of the day. The most striking changes were the 23 percentage point increase in support for, *and* the 15 percent decline in opposition to *Reorganize service delivery*. Note that there is no change in the rank order. *Reorganize service delivery* was the most favoured scenario in the morning, with 56 percent support, and it gained the most support over the course of the day, reaching a remarkable 79 percent, with opposition shrinking to only 10 percent. Support was strong across all income groups and age groups with the older population being most positive.

A sampling of participants' statements on the questionnaire of the conditions on which they rated Scenario 4 also reflects the logic they worked through. Citizens want "a focus on wellness," "an integrated, holistic, accessible concept," "to take advantage of technology: e-doctors and e-medicine," but they also expect that "it won't get too bureaucratic," " a second opinion can be obtained for a user fee," and "you can choose your network."

More public investment ranked second both in the morning and at the end of the day. It was rated favourably by 61 percent of participants at the end of the day, up from 48 percent. Opposition to more public investment dropped from 33 to 23 percent. Young people and high-income earners accounted for the biggest positive shifts, during the day. The strongest support came from people over the age of 65 and those with modest to middle incomes.

Again the conditions are predictable. "I must have a guarantee that the money will be used for health." [Translation] "The monies that are already in the system are more wisely spent!" "Only after reorganization." "With full accountability for efficiencies."

The enthusiasm for the copayment scenario – *Share the costs and responsibilities* – is more muted. Support rose modestly from 45 percent in the morning to 50 percent at the end of the day. Opposition declined by 9 percentage points from 39 to 30 percent, but this is the only case where the number of undecided people actually increased slightly to 20 percent. There were no significant differences across socio-economic groups for this scenario.

Thus citizens continue to be ambivalent about this scenario. The ambiguity is consistent with what transpired during the dialogue. The attitudes of the vocal minority that strongly opposed user payments are illustrated well in their conditional statements. "I find user fees and privatization inefficient, elitist, abhorrent and bound to degrade the system." "A ruse for privatization – favours the 'haves' who are then financed by the 'have-nots'." The 50 percent of citizens who could see some merit in user fees at least for some limited purposes were looking for the following conditions to be met: "Some basic coverage is in place for all users, regardless of their economic condition," "Poor can still access care," and "Abuse is stopped."

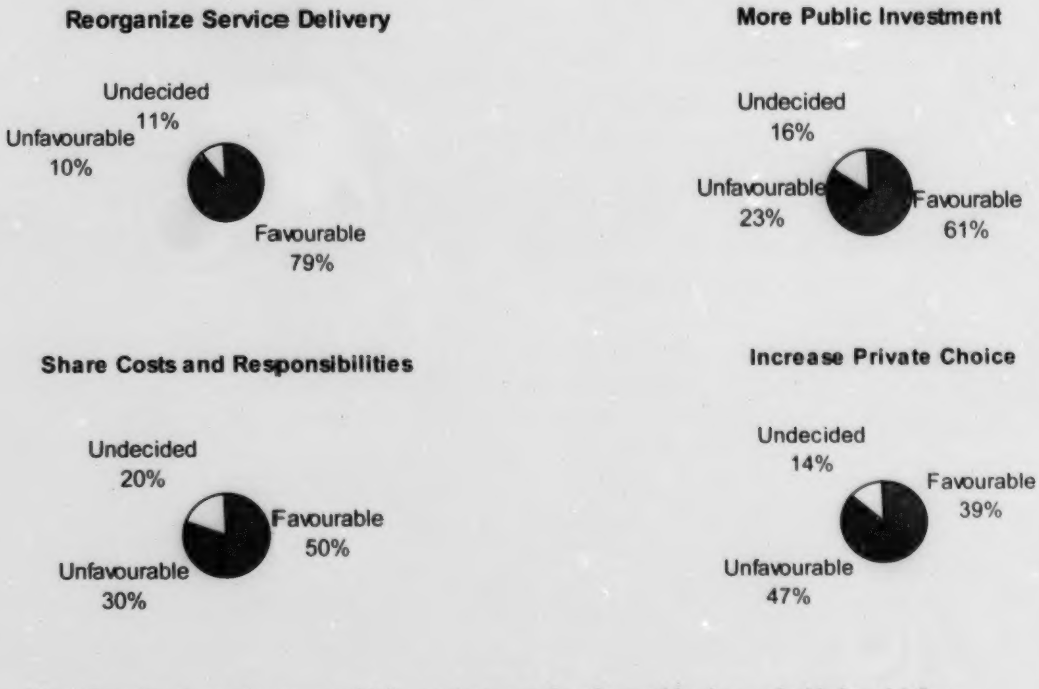
Finally the *Increased private choice* scenario started out the day as the least preferred and remained so at the end. This is the scenario where views appear to change the least. Support increased by 5 percentage points – from 34 to 39 percent. And the opposition declined by only 3 percentage points. Women and people over the age of 65 were less likely to support this scenario, and people with low to average incomes were also less favourable than those with higher incomes.

Citizens who were initially open-minded about Scenario 3 explained in the dialogues that they ultimately rejected the scenario because of the negative impact on the public system. Thus the conditions that appear in the post-dialogue questionnaire are: "the public system improves and does not deteriorate"; "it does not negatively impact provision of public services and that any potential conflict of interest opportunities are eliminated."

The pie charts in Figure 8 summarize, by scenario, the percentage of citizens in favour, not in favour and undecided. They provide a direct comparison with the pre-dialogue charts displayed in Figure 6, Chapter IV.

Figure 8

Post-Dialogue Questionnaire Results



Reorganize Service Delivery

More Public Investment

Share Costs and Responsibilities

Increase Private Choice

Note: On a 7-point scale, scores of 5-7 were interpreted as favourable, 4 as undecided, and 1-3 as unfavourable.
Source: Citizens' Dialogue on the Future of Health Care in Canada.

In summary, 489 citizens, forming a representative sample of the Canadian population, did their best to come to terms with the health care dilemmas in Canada. They explored options, weighed the pros and cons of each, faced up to trade-offs, and used their core values to make their best choices. The project team has a high degree of confidence in these results for the simple reason that they were reproduced 12 times.

The Follow-Up Survey

A national survey was conducted following the 12 dialogue sessions to provide an additional measure of the extent to which the results of the dialogues can be generalized with confidence to the wider population.[16] During March 2002, 1,600 Canadians responded by telephone, using a questionnaire that drew from the dialogue results as well as past research of Ekos Research Associates, the survey research firm.

Overall, the findings of the survey are consistent with the dialogue results. At the same time, there are variations that reflect the differences between the two research techniques, each of which has its own distinctive capabilities. A 14-minute questionnaire cannot replicate a day of dialogue but it can provide a reliable snapshot of representative views, attitudes and values statements at a point in time. Survey findings can be interpreted with greatest confidence when people have made up their minds about an issue. When people have opinions that are unstable, inconsistent and partially formulated, as was found to be the case here, polls are not designed to predict how those opinions will shift with more information, discussion and testing against core values.

Because it was impossible in a 14-minute survey questionnaire to replicate the dynamic of the dialogues and the citizens' process of working through complicated issues, the survey was designed to test reactions to the scenarios, the arguments pro and con each scenario, the conditions used by citizens to explain the reasons behind their choices, and the values.

Similarities and Differences

Telephone respondents were asked to indicate their support for, or opposition to, each of the four scenarios, as described for them in a single sentence distilled from the descriptions used in the dialogue sessions.

Survey respondents ranked the scenarios in the same order as did dialogue participants:

1. Reorganize service delivery;
2. More public investment;
3. Share costs and responsibilities; and
4. Increase private choice.

However, the dialogue scores for the four scenarios all show lower levels of approval than the poll scores (both pre- and post-dialogue). The biggest difference occurs in relation to the *More public investment* scenario. The poll reports a 79 percent level of support for increasing public investment, in contrast to a 61 percent level of support after dialogue. A similar pattern characterizes the other scenarios: 63 percent of poll respondents support the *Share costs* scenario, in contrast to 51 percent of dialogue participants after their day-long dialogue. For *Increase private choice*, the contrast is 49 percent (poll) vs. 39 percent (after dialogue). For *Reorganize service delivery*, the scores are 81 percent (poll) vs. 79 percent (after dialogue). Other compatible findings are described later in this chapter.

The differences between the poll findings and the dialogue results are revealing both from a policy and technical perspective. One important difference carries important policy implications. On the surface, the poll findings suggest that from a public preference point of view, the *More public investment* scenario and the *Reorganizing service delivery* scenario are neck and neck – 79 and 81 percent.[17] However, the response to a follow-up question in the poll explains why *More public investment* receives comparatively greater support in the poll than in the dialogues. The follow-up question asked those who favoured public investment whether the investment should come from higher taxes or from reallocating public expenditure. In response, 79 percent opted for reallocating public expenditure, and only 17 percent for tax increases. For the telephone respondents, more public investment means reallocating expenditures, not raising taxes.

As reported in Chapter V, re-allocation was also the initial response of the dialogue participants. They only changed their minds when they found it impossible to specify which expenditures should be cut to make room for health care. And this impasse forced them to look more closely at other scenarios, especially copayment or the parallel private system. When these too were rejected, 61 percent of dialogue citizens eventually came to terms with higher taxes, but with the very specific conditions described in Chapter V.

Other differences between the poll and the dialogue results are technical in nature. For example, the poll used a 4-point scale while the dialogues used a 7-point scale.[18]

Overall, the telephone respondents and the dialogue participants started with similar views about the health care system. The dialogue participants had more time and were given the freedom to choose or combine scenarios. They used this opportunity to work through the tensions between the desire for more public investment and the dislike of paying more taxes. A number of other consistencies show up when the telephone respondents were given a chance to react to the way in which the dialogue participants expressed the key conditions for their choices.

The Arguments and Conditions

The arguments for and against the scenarios, and the conditions that dialogue participants specified for their support of each scenario, also resonated with poll respondents.

When the argument was used that "taxes are already high enough; it is just that the system needs to be more efficient and innovative," 69 percent of respondents agreed. The major condition for supporting increased public investment is cost-effectiveness and accountability for how money is spent. (The second most frequently supported condition is that the increased taxes should go only to health care). Consistent with the dialogues, support for more public investment is contingent on these conditions.

Although 63 percent of poll respondents supported user fees, their conditions for acceptance reveal more divided and complicated opinions. When presented with the pro and the con arguments, a slim majority (56 percent) endorsed the view "that user fees will make people more responsible in how they use the system and also keep taxes lower" as closest to their own views. But at the same time a significant minority (42 percent) shared the perspective "that those less well off will forego treatment whereas it won't matter to the rich."

This division also appears in the conditions explored by the dialogue participants. Thirty-nine percent of telephone respondents chose a subsidy for low-income people as the most important condition for introducing user fees. But a very similar proportion, 35 percent chose the condition that the user fees must "reduce abuse of the system."

Telephone respondents were also deeply concerned about waste and misuse as were dialogue participants. But in the course of the dialogues, participants found a way to balance their concern about abuse of the system by patients with their concern that those less well off would suffer if user fees were imposed. Participants in dialogue after dialogue concluded that information systems (for example, smart cards) could be used to track and limit abuse and that this would be a better way to address that problem than user fees, since it would ensure that those less well off would not be disadvantaged. Again, in a dialogue, participants have an opportunity to work through complicated issues with others and reach judgment in a way that is not possible (nor is it the objective) in a brief poll.

In the poll, as in the dialogues, there was strong opposition to increasing private choice through a parallel private system. Consistent with the dialogue results, more than two out of three poll respondents believe that people should have access to care based on need not ability to pay, and that more private care will drain resources from the public system. Lagging far behind are those who believe that people with more personal resources should have the right to choose faster and better quality services and that this will take pressure off the public system (30 percent).

In the poll, respondents stated their top condition for a parallel private system to be "… a public system, with national standards available to anyone who cannot afford the private system" (49 percent). A slight variation on this condition, "that the overall quality of the public system be maintained," was the second most frequently chosen (36 percent). Taken together, 85 percent of poll respondents were worried about the future of the public system if a private one was allowed to flourish. As in the dialogues, access based on need for timely quality care trumped freedom of choice.

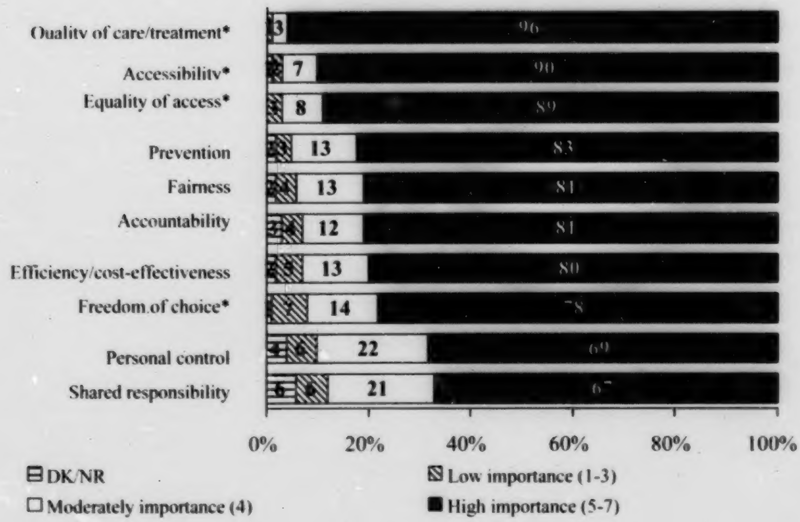
In exploring the conditions for supporting or opposing the scenario on *Reorganizing service delivery*, the telephone survey and the dialogue results also were consistent. Two-thirds of poll respondents (67 percent) said they liked the idea of "one-stop shopping to treat the whole person." This is also what first attracted dialogue participants to the scenario. At the same time, 28 percent of poll respondents expressed concern that this scenario could mean a rigid system with efficiencies gained at the expense of personal choice of professionals and second opinions. Again, this is consistent with concerns expressed by dialogue participants, although those in the dialogues then had an opportunity to work through their concerns with each other, and in that process support for this scenario increased further.

Values

Survey respondents were also asked to rate the importance of a series of values identified in the dialogues and in other Ekos projects. They were one word or short phrase statements and there was no attempt to nuance them as citizens had done in the dialogues.

In the top tier of greatest importance to respondents are the values of quality of care/treatment, accessibility and equality of access. Respondents group the values of prevention, fairness, accountability, efficiency/cost-effectiveness and freedom of choice into a second tier of slightly less importance (see Figure 9).

Figure 9
Values



DK = don't know; NR = no response.
Note: Survey of 1,600 Canadians.
* One-half of the sample.
Source: Ekos Research Associates, *Report on the Future of Health Care in Canada: General Public Survey*, Ottawa, March 2002.

These findings are generally consistent with those of the dialogues, although in the dialogues the importance of accountability and prevention grew throughout the day as citizens worked through the issues and trade-offs. It is also difficult to interpret the meaning of the "freedom of choice" value that poll respondents rank highly. It could have a meaning similar to the dialogue participants' desire to influence treatment decisions within the public system (which they valued highly); or it could have the connotation of "freedom to purchase private services," which was not strongly supported in the dialogues. Given that poll respondents, too, generally did not support the scenario of increased private choice, the first interpretation is more likely.

The survey reveals that health status and income make a difference in people's initial responses to reform ideas. Good health status and high income are correlated with greater support for both user fees and more private choice. By the end of the dialogues, there was a high degree of convergence in views on all the scenarios across socio-economic groups, with one exception. High-income participants in the dialogue were the strongest proponents of private choice.

Summary

The survey results and the dialogues both demonstrate that Canadians are ready to support reform of the health care system consistent with their core values and principles. They are prepared to consider a range of changes and innovations to care and service delivery including but not restricted to primary care. They are looking for cost-effectiveness and accountability. When it comes to paying for health care, they favour public funding to the alternatives. And the dialogue participants, in particular, favour innovative changes that embody the values of prevention and concern for the whole person.

In short, the telephone poll confirms the broad outline of the outcomes from the citizen dialogues. But the dialogues go beyond the poll in ways that open new avenues for public policy.

VII Conclusions

Citizens' Conclusions

At the end of the day of dialogue, participants made closing comments to their fellow citizens and to the Commissioner. The microphone was passed from one citizen to the next, so that every person in the room had a chance to speak directly to the Commissioner. The facilitator asked them to respond briefly to three questions:

- How have your views evolved over the course of the day?
- What is the most important insight you have had today?
- What is one message you hope will be communicated to Commissioner Romanow and decision makers?

Tired after their long day, citizens were nonetheless elated and passionate about what they had accomplished. Those that were shy in the opening statements were much more confident about what they wanted to say. They thanked their colleagues effusively for the pleasure of working with them, and expressed with great emotion their sense of solidarity with their fellow citizens. They stated their conviction that reform is needed, they affirmed their support for the consensus choices and the trade-offs and, if they held minority views, they restated them.

Many testified to the transformative effect of the dialogue. They acknowledged that their views had changed. Others made pledges to take better care of their own health, through exercise, and healthier habits. They spoke of their great respect for the views of others in the room. And they acknowledged how challenging the policy choices will be for the Commissioner and for public authorities. Whatever the ultimate policy decisions are, these citizens will have a better understanding of why they were made.

"I liked my group – especially the respect I was shown when giving my opinion... I loved my day." [Translation] [Québec City]

Three overarching themes kept getting repeated.

Reform Is Complex

Participants now have a better understanding of how intricate the system is, how complex an approach to reform needs to be, and that there is no "easy fix." Individuals who came thinking there was a single issue to be addressed left with an appreciation of the many issues. "I thought it was about budget cutting, but there are many issues that need to be looked at."

Many individuals acknowledged that they now see the validity in other viewpoints and that their views have changed. Some who came adamantly opposed to certain actions left with open minds. This is articulated as "reform is a complex issue." And it is consistent with the quantitative results indicating greater openness to all four scenarios.

Reform Must Be Thoughtful

Understanding that the health care system is complex and recognizing that both the changes they want and are willing to accept will have profound impacts on the status quo, citizens want decision makers to be careful in the design and speed of reform. They do not want decision makers to leap to some quick fix that later will need to be redone or undone because of its unanticipated consequences. Citizens want the assurance that any changes are well researched and, preferably, piloted, especially if reform ideas are being imported from abroad. But they also feel that time is of the essence, and want no unnecessary delay in testing and implementing reform.

Citizens Need to Be Engaged

Citizens felt they had benefited personally from their participation in the dialogue. They thanked the Commissioner. They spoke of being enlightened and of having learned. The experience is described as truly valuable. "This has been enriching and all Canadians should experience this."

The Dialogue empowered these citizens and left them with the firm conviction that governments must listen to what they have said and "make use of the information." If the question is "how to get better health care for the users," citizens spoke of themselves as "better judges of the system than those who deliver." They want governments to listen to them and to respond. Good and appropriate health care reform must involve citizens – not just this year, but over the long term. Long-term planning and evaluation needs to engage citizens as well as stakeholders. They were delighted that someone had finally undertaken the dialogue process and wish it had begun long ago, and they also hope it will not be just a one-time event.

Policy Conclusions

The Commission on the Future of Health Care in Canada decided to undertake a new kind of dialogue with citizens because it wanted to give the public a clear and thoughtful voice in the health care debate at a key turning point in the history of Medicare. As the Commissioner said in his letter to dialogue participants:

> There are no right or wrong answers here. What I want from this research project is a better sense of what you collectively value as important and believe to be the right path to take and why. I want to understand what aspects of the solutions you prefer – and do not prefer – in order to better focus my Commission's final recommendations.[19]

Citizens did not pick one scenario. They found common ground using three out of the four scenarios. And they went beyond the scenarios, weaving together a new synthesis of their social, economic, and political values to update the health care contract that underlies Medicare. They also explained why they made the choices they did. They have given the Commissioner a rich portrait of what they collectively value as important and believe to be the right path to take.

Much has been written in the past decade about the decline in deference for political institutions and weak participation in the political process. Canadian participation in national elections and in political parties has been falling. Yet, when Canadians are asked to rank the things that matter to them for their quality of life, they list their political rights near the top of the list.[20] This suggests that Canadians are looking for new and different ways to participate in the political life of their country.

Canadians' response to the Citizens' Dialogue on the Future of Health Care in Canada is a testament to that desire to participate. In their random telephone calls, Ekos Research Associates found it easy to interest potential participants in the project, even though people were asked to commit a full day on a weekend and in some cases to travel long distances. Almost all of those who accepted showed up at the appointed time and place, despite the usual travel hazards of the Canadian winter.

Once engaged in the dialogues, they showed unfailing energy, over an eight-hour session with only one short break. They were sophisticated, passionate, spontaneous, thoughtful, and, in the end, logical and consistent in their conclusions. They covered territory that went well beyond the expectations of the organizers. Independent observers at the individual sessions were astonished at the quality of the engagement. They would have been even more astonished if they had had a chance to observe how much common ground there was across the 12 dialogue sessions, involving citizens from coast to coast, from rural and remote settings, from suburbs and inner cities.

As they came to know and respect the 40 strangers in their dialogue session, the participants were amazed at how much they had in common with their fellow citizens. They delighted in the diversity in the room, and almost unanimously adopted the "rules of dialogue" explained by the facilitators. As they came to understand that the session was designed for their use, they facilitated their own small groups, and seized the opportunity to learn, to talk to each other, and to speak directly to the Commissioner through the video camera.

Participants struggled with the contradictions in their own values. It was relatively easy to construct a wish list of what they wanted from the health care system. It was more difficult to decide how to pay for it, and who should pay. In the end, they dropped things from their wish list, and relented on their aversion to tax increases.

By the end of the dialogues, citizens agreed to make adjustments in their own behaviour, and to change the way they interact with the health care system in ways that would have been unimaginable 10 years ago. As they began to work through these more difficult choices, participants felt like "real citizens." They engaged.

What then are the consequences of this dialogue for health care reform and more generally for public policy in Canada. Let us begin with health care reform.

Implications for Health Care

The first implication for health care policy is a wide gap in perception between the public and health care elite. The elite has spent 10 years reforming the system to make it more cost-effective. Many of them feel that the efficiency gains have been harvested. But citizens are insisting that there is much more to do. What citizens seem to be saying is that the restructuring of the 1990s has had relatively little impact on the everyday services used by the majority of Canadians. Citizens have most of their day-to-day contacts with solo practitioner doctors, clinics, and emergency rooms, where modes of service delivery have not changed for a long time. The other message from citizens is that the restructuring in their community has not increased their sense of confidence that the system is well managed and on a sustainable course.

The main purpose of the Dialogue was to surface core values and provide insight into how citizens will use their values to make difficult choices and trade-offs. These values are not fixed in time and space. They evolve over time, as human experience and public context change. They are one essential ingredient in public policy choices. The other essential ingredient is the technical knowledge of experts and stakeholders – the people who are trained to work in the health care system and to analyze it. Values and technical knowledge each have an essential role to play in informing good public policy. The values define the boundaries of action in a democracy, and thus provide the framework within which technical knowledge can be applied.

It is important to recognize that these two roles are distinct and should not be blurred. Citizens can provide the values framework, but they do not have the technical knowledge. They can express their need for access to integrated, multi-disciplinary responsive care, but they cannot make the technical choices about how health care teams should be formed, managed, financed, and so on. Technical experts, for their part, should have no special standing in the values discussion because of their technical expertise. Their values are no more important than those of any citizen in making these difficult choices.

The Commission on the Future of Health Care in Canada has invested its time and money in collecting both kinds of information. Through its intensive interaction with providers, managers, governments, and other stakeholders, it is gaining a strong sense of the current state of knowledge about the technical options for reform – clinical, fiscal, organizational, and so on. Through this Citizens' Dialogue, the Commission has undertaken the most intense examination of the health care values of Canadian citizens to date.

Canadians' health care values have evolved over the past decade. What citizens have begun to do is to integrate their economic and political values with their social values in ways that put a harder edge on the health care contract and its reform.

- They prize the health care system in Canada, and they want to conserve it. But, they have come to the view that we cannot fix health care simply by putting more money into the existing system.

- They see health care as a shared resource for all citizens. This creates a sense of solidarity and connection to each other and to the country.

- But they also see health care as a scarce resource – one that is to be used judiciously and with a clear sense of what is cost-effective.

- They see health care as a means to an end, and the end is wellness. They understand that good health comes mainly from good genes plus healthy living, which is their own responsibility. At the same time, they believe that public institutions, from Parliament to the local school board, also have a role to play in contributing to prevention and promotion.

- They also see prevention and health promotion as a way to conserve health resources in the longer term – an investment that will reduce future demand for health care services. But they do not see prevention and promotion as a substitute for health services in the short term.

- They no longer defer to the authority of health care providers and governments. Rather, they demand greater efficiency, transparency, and accountability.

- They also yearn for a more responsive system that gives citizens some influence over the choice of treatment.

- They have adopted the new technologies and put them into their health service toolbox. Equal access is still their mantra, but, in a 24/7 world, they need and want a different kind of access to health services. And they see the technologies as a double win – a way to improve access *and* make gains in efficiency.

- They make a commitment to a much tougher set of personal accountabilities in the way they use the health care system.

Citizens are ready to adopt new ways of interacting with service providers, which policymakers have usually assumed would be resisted. When given a chance to work through the issues, citizens are far more open to change in the delivery of health care services than most politicians imagine. Citizens are ready for change in order to preserve the essence of Medicare, while adapting it to new realities. But they also set very clear and challenging conditions for their consent. This means there are opportunities for health care reform that did not exist as recently as six years ago. These Canadians have seen the logic of the more integrated care model which has been recommended by many commissions and inquiries over the years, and they like it.

Yet, this consent for reform is conditional. Governments should take notice of the harder edge in Canadian health care values. Citizens' anger about inefficiency, lack of accountability and political gamesmanship is a sign that their patience is short. If this round of discussion of health care reform does not lead to substantive improvements, then Canadians may well decide that they have to consider other possibilities.

Implications for Public Policy

Turning now to the question of public policy more generally, this health care dialogue opens up new horizons in policymaking in at least three broad domains – social and economic policies, wellness, and the way we practice democracy.

Traditionally, social and economic policy ministries have operated in independent silos. As a result, little attention has been paid to the way these two important branches of public policy impact on each other. In the dialogues, citizens found ways to integrate their social and economic values into a new synthesis for health care. The question to be raised now is whether and how more integrated approaches can be developed and pursued across the spectrum of social and economic policy.

On the issue of wellness, prevention, and promotion, citizens were remarkably consistent from coast to coast. Observers wondered if Canada is on the cusp of a major societal shift from a disease-based to a wellness-based way of thinking. Citizens have a well-rounded view of wellness. It is a personal responsibility, a result of good fortune, and a state responsibility. The state responsibility cuts across nearly every ministry of government including industry, environment, housing, transport, natural resources, agriculture, education, and more. Citizens feel vulnerable to health risks in the air, water, food and drugs that they consume. The combination of their vulnerability and their desire to live a healthy life creates a remarkable opening for healthy public policy, across the spectrum of government programming.

Finally, but perhaps most important, is the willingness and capacity of Canadian citizens to take up the opportunity to engage in a dialogue of this sort. What does this will and capacity to engage mean for the way that Canada practices democracy?

Citizen involvement in public policy embraces a wide range of activities and instruments from communications, to consultation, to engagement. Together they serve as the means to strengthen the credibility and the functioning of public institutions. Policymakers have to make strategic choices about when to use engagement in order to match the instrument to the situation.

Engagement is needed when public policy is at a key turning point. This usually occurs when a society is reassessing its options, setting priorities, mapping the boundaries of where major change is possible. It is needed when a society is in a rapid transition, where there are crosscurrents of change that are transforming the lives of citizens. Engagement helps to clarify how deeply held values are evolving with the changing circumstances. The legitimacy and sustainability of our most important public policies depend on how well they reflect those underlying (and evolving) Canadian values. But engagement only works when policymakers are ready to invest in learning and listening, when they are ready to open up a discussion on the big conflicted choices and trade-offs, and when they place a high value on the process of public learning.

The public learning experienced by the citizens in the health care dialogue had a transformational impact on their thinking on many issues. It changed the way they articulated their own responsibilities, it increased their respect for the complexity of the health care problem, and it will probably make it much easier for them to understand the decisions that flow from the Commission's work.

Concluding Comments

This dialogue has given citizens an opportunity to update their fundamental values for health care. Their lives have changed profoundly since the 1960s, and their values have evolved as a result of that experience.

This restatement of values has major implications for public policy. It should lead to changes in the principles that govern the health care system, to the way the health care system is managed, and to the focus of public policy on a much broader array of programs that influence the health of the population.

Citizens have had their say in the winter of 2002. They said it well and with passion. It was a privilege to witness their Dialogue.

Appendixes

Appendix 1 – Basic Steps in a ChoiceWork Project

1) Archival analysis of polls (or conducting a special one) and other research to provide a baseline reading on what stage of development public opinion has reached.
2) The identification of critical choices and choice scenarios on the issue and their most important pros and cons.
3) A series of one-day dialogue sessions with representative cross-sections of stakeholders. Each dialogue involves about 40 participants, lasts one full day and is videotaped. A typical one-day session includes the following:
    - Initial orientation (including the purpose of the dialogue and the use to be made of the results, the nature of dialogue and ground-rules for the session, introduction of the focal issues and some basic facts about them);
    - Introduction of the choice scenarios on the specific focal issue, and a questionnaire to measure participants' initial views;
    - Dialogue among participants (in smaller groups and in plenary) on the likely good and bad results that would occur as a consequence of each choice if it were adopted, and constructing a vision of the future they would prefer to see;
    - A second, more intensive round of dialogue among the participants (again both in smaller groups and in plenary) working through the concrete choices and trade-offs they would make or support to realize their vision;
    - Concluding comments from each participant on how their views have changed in the course of the day (and why), and a questionnaire designed to measure those changes.
4) An analysis of how people's positions evolve during the dialogues. We take before and after readings on how and to what extent people's positions have shifted on each choice as a result of the dialogue. (Some of the shifts are huge.) This analysis is both quantitative and qualitative.
5) A briefing to leaders to make sense of the results. The briefing summarizes what matters most to people on the issue, how positions are likely to evolve as surface opinion matures into more considered judgment, and the opportunities for leadership this creates.

Appendix 2 – Dialogue Dates and Places

January 19, 2002	Montreal (English)
January 20, 2002	Montreal (French)
February 2, 2002	Vancouver
February 9, 2002	Halifax
February 9, 2002	Thunder Bay
February 10, 2002	Halifax
February 16, 2002	Calgary
February 16, 2002	Bathurst (French)
February 23, 2002	Regina
February 23, 2002	Québec City (French)
March 2, 2002	Toronto
March 2, 2002	Ottawa

Appendix 3 – Facilitators' Prompts

To reduce costs and improve efficiency, are we prepared to:

- use a telephone hot-line or 24-hour clinic rather than hospital emergency
- see a nurse rather than a doctor for routine treatments
- see a nutritionist or a social worker rather than a doctor
- make our personal information available on a smart card
- spend time learning about prevention and how to act more responsibly
- sign up with one family doctor for at least a year
- see our choice of hospitals limited
- see our ability to get a second opinion limited

How to pay for what we want:

- tax increases
- reallocation of government spending – federal and provincial
- user payments (out-of-pocket)
- private insurance
- private sector investments
- reorganized service delivery – limiting choices and improving efficiency
- dropping (delisting) of some covered services

Should people be able to buy private insurance to obtain from a private provider:

- eye glasses
- dental care
- drug coverage
- physiotherapy treatments
- naturopath consultations
- home care services
- faster diagnostic services such as MRI or CAT scan
- delivery of a baby in a private clinic
- hip replacement in a private clinic
- cataract surgery
- heart by-pass surgery
- cancer treatment

Appendix 4 – Quantitative Findings

Table 1
Summary of Pre- and Post-Dialogue Positions and Shift per Scenario

Scenario	**Pre-dialogue**	**Post-dialogue**	**Shift**
Percent of participants			
More public investment			
Favourable	48	61	+13
Unfavourable	33	23	+10
Net	+15	+38	+23
Share the cost and responsibility			
Favourable	45	50	+5
Unfavourable	39	30	+9
Net	+ 6	+ 20	+14
Increase private choice			
Favourable	34	39	+5
Unfavourable	50	47	+3
Net	- 16	- 8	+ 8
Reorganize service delivery			
Favourable	56	79	+23
Unfavourable	25	10	+15
Net	+31	+69	+38

N. B.: Figures represent percent of participants voting at the beginning and at the end averaged across the 12 dialogues. The net shift shows the increase in favourable votes plus the decline in unfavourable votes over the course of the day.

Table 2
Summary of Pre- and Post-Dialogue Mean Scores
(on a Scale of 1 to 7, Where 7 Is High)

Scenario	**Pre-dialogue**	**Post-dialogue**	**Shift in points**	**Percent shift**
More public investment	4.33	4.80	+0.47	10.8
Share the costs and responsibilities	4.07	4.36	+0.29	7.1
Increase private choice	3.52	3.73	+0.21	6.0
Reorganize service delivery	4.58	5.64	+1.06	23.1

Appendix 5 –

Workbook

Citizens' Dialogue on the Future of Health Care in Canada

A project undertaken for the
Commission on the Future of Health Care in Canada by:
Canadian Policy Research Networks
Viewpoint Learning

Table of Contents

Welcome from the Commissioner

Introduction

The Issue
Purpose of Today's Meeting
Agenda for the Day
Background
Summary of the Four Scenarios

Using Dialogue:

Debate vs. Dialogue
Ground-Rules for Dialogue

Four Scenarios:

Scenario 1: More Public Investment
Scenario 2: Share the Costs and the Responsibilities
Scenario 3: Increase Private Choice
Scenario 4: Reorganize Service Delivery

Dear Dialogue Participant,

Thank you for agreeing to take part in this important initiative.

Our health care system is one of our country's proudest achievements. It has served us well over the years, and many Canadians consider it to be a defining element of their citizenship.

But in recent years, despite all of its undeniable successes, it sometimes appears as though the system can no longer measure up given all the demands placed upon it.

Many Canadians cite the future of their health care system as being the single-most important issue facing the country. Indeed, my primary responsibility as Commissioner is to address the issues that are eroding public confidence in the system's future, to ensure it continues to deliver timely, quality care on the basis of need, and to recommend ways to place it on a more sustainable footing for the future.

There is considerable debate as to whether our health care system needs fine-tuning or a major overhaul. And as you might imagine, there are many different perspectives on where to look for solutions. As part of the *Dialogue with Citizens* project, you will have a chance to reflect on the relative merit of certain of these perspectives and their solutions. Each reflects some assumptions about what Canadians value most and want to see reflected in the policies and programs that define their health care system. And while each suggests a distinct path with different choices, all seek a similar destination: a modern, sustainable health system offering all Canadians timely access to quality care.

There are no right or wrong answers here. What I want from this research project is a better sense of what *you collectively* value as important and believe to be the right path to take and why. I want to understand what aspects of the solutions you prefer — and do not prefer — in order to better focus my Commission's final recommendations.

I am grateful that you have accepted to take part in this Dialogue. It is one of 12 being held across the country over the coming weeks by the Canadian Policy Research Networks and Viewpoint Learning on behalf of the Commission. I'm confident you will find the experience to be both rewarding and enriching.

Sincerely,

Roy Romanow

INTRODUCTION

The Issue

The conditions under which Medicare started in the 1960s were very different than they are now and will be in the future. The population was smaller and younger. The number and cost of services that were regarded as medically necessary were less. With an aging population and an explosion of technology that permits the health care system to offer many more services, Medicare has begun to show stresses and strains over time. **Today that stress shows up in the form of rising costs, dissatisfaction and questions about what new health services should be covered.**

Adjusting for inflation and population growth, **between 2000 and 2020 total health care spending in Canada, both public and private, is predicted to grow by 56% — from $2,626 per person to over $4,100.**[1] Total spending will rise from $81 billion to $147 billion.

A decade ago, a majority of Canadians (61%) were satisfied with the system; today, that number has been cut in half to fewer than one in three (29%).[2] Canadians speak of difficulties in finding a family doctor when they move to a new community.[*] They are concerned about how long people spend waiting in hospital emergency rooms, or to see a specialist or for surgery.[3]

In the 1960s when Medicare was first introduced, it matched people's needs to be able to consult a doctor or go to a hospital when necessary. But times have changed, and **other services are increasingly important**, for example:

- **Prescription drugs** are the fastest growing component of health care costs (today we actually spend more on drugs than we do on physician services) but for most people, Medicare does not cover the cost of drugs outside of hospitals;
- **Home care** has been growing rapidly, with about 1 million Canadians receiving some type of publicly funded care in their homes in 2000.[4] Yet

---

[*] A recent survey found that across Canada 60% of family physicians were not generally accepting new patients. College of Family Physicians, "2001 National Family Physician Workforce Survey".

the extent to which such services are available or provided by the public system varies widely from province to province.

Canadians want to improve services not just for today but also for the foreseeable future. Large majorities of Canadians tell us that everyone should be able to access a public system for care whenever they are sick or injured, and that health care should be provided based upon need rather than ability to pay.[5] Citizens want to ensure that:

- The system will have adequate resources;
- It will cover the right health services;
- The system will function as efficiently as possible, so that Canadians get the best possible care for the least possible expenditure of money, and
- Any and all changes made will conform to fundamental Canadian values.

There are, of course many different ways to achieve these objectives. We need to work through, as Canadians, which course we want to follow — what choices and tradeoffs we are prepared to make to shape the future for our health care system.

The Purpose of Today's Meeting

- The purpose of today's meeting is for us as Canadians to wrestle with how best to deal with these and related challenges to the future of our health care system. We are going to spend most of the day considering four choices or scenarios for the future of health care in Canada. Each scenario presents a realistic course we might choose for the future, and each reflects the stated views not only of many experts but also of a substantial number of Canadians.
- By the end of the day we may select one of the scenarios, we may invent a fifth made up of parts of the others, or we may end up sharply divided on which choice is best. At the very least we will have had a good discussion and all of us will come away with a better understanding of the issues.
- What should we expect the day's dialogues to produce? None of us are technical experts. So we don't expect to end up with a set of expert recommendations and policies. All of us are Canadians with our own values and points of view. It is up to us as citizens to say what we want our governments to do with our tax dollars and how we want to shape our future. Experts can provide information, but they can't make those choices for us.
- This is one of 12 dialogues being conducted across the country for the Commission on the Future of Health Care in Canada. We will report the results of these dialogues to Commissioner Romanow to help in his deliberations, and each of you will receive a copy of our report.

Agenda for the Day

Opening comments

Initial judgment

Introducing ourselves

What we want health care in Canada to be like in 10 years

Lunch

Which choices are best to move us toward
the health care system we want?

Final judgment

Identifying the most important insights from the day

Closing comments

BACKGROUND

Solutions to our current problems must be found within Canada's constitutional arrangements:

- Provincial governments are responsible for delivering health care.
- The federal government gives the provinces money to spend in accordance with the principles of the Canada Health Act. The federal government also plays a direct role in health protection and promotion, disease prevention, research and in providing health care for certain groups like Canada's First Nations.
- Of the $67.6 billion in public funds spent on health care in 2000, the provinces provided about 65%, the federal government 35%.[*][6]
- As a result of this division of responsibilities, while Medicare systems across the country reflect the principles of the Canada Health Act, there are differences from province to province in how they operate and what is covered.

The 5 principles of the Canada Health Act are:

1. Universality (Everyone is covered);
2. Comprehensiveness (All necessary hospital & physician services are covered);
3. Accessibility (The system is accessible to all Canadians without financial or other barriers);
4. Portability (Everyone is covered wherever they move or travel in Canada);
5. Public administration (Health care plans must be administered by public authorities responsible to provinces).

Today, Medicare pays 100% of the cost of all medically necessary services provided by doctors and in hospitals. But in recent years services not covered by Medicare, such as prescription drugs and home care, have become more important.[**] **Compared to other countries, Canada provides more publicly funded coverage for hospital and physician care, and less for other services such as prescription drugs and dental care.** [7]

---

[*] The federal share of 35% includes some tax points (ie. power to tax) transferred to the provinces in 1977. If the tax points are not included, then the federal share is about 18% and the provincial share is 82%.

[**] For example, the cost of hospitals and doctors today represent just over 45% of total spending on health care compared to 57% in 1984.

About 70% of total spending on health care in Canada is from public funds. The remaining 30% is paid by Canadians out of their own pockets or through private insurance and goes principally for dental care, vision care, prescription drugs, long-term care and the services of professionals other than doctors such as chiropractors, physiotherapists and naturopaths.[8]

Summary of the Four Scenarios

More public investment. The first scenario is to add more resources (such as doctors, nurses, and equipment) to deal with Medicare's current problems by increasing public spending, either through a tax increase or by re-allocating funds from other government programs.

Share the costs and responsibilities. The second scenario is to add more resources to deal with current problems not by increasing public spending but through a system of user co-payments for health care services, that would provide an incentive for people not to over-use the system as well as needed funds.

Increase private choice. The third scenario is to give Canadians increased choice in accessing private providers for health care services. Side-by-side with the public system, Canadians also could access health care services from a private sector provider (either for-profit or not-for-profit) and pay for it from their own resources or private insurance.

Reorganize service delivery. The fourth scenario is to reorganize service delivery in order to provide more integrated care, realize efficiencies and expand coverage. Under this scenario, each Canadian would sign up with a Health Care Provider Network that would work as a team to provide more coordinated, cost-effective services and improved access to care.

USING DIALOGUE

Our meeting today is designed to be a dialogue. Dialogue is a special kind of conversation that draws on a diversity of points of view to develop insight and build common ground.

Debate vs. Dialogue

Debate	**Dialogue**
Assuming that there is one right answer (and you have it)	Assuming that others have pieces of the answer
Combative: attempting to prove the other side wrong	Collaborative: attempting to find common understanding
About winning	About finding common ground
Listening to find flaws	Listening to understand
Defending your assumptions	Bringing up your assumptions for inspection and discussion
Criticizing the other side's point of view	Re-examining all points of view
Defending one's views against others	Admitting that others' thinking can improve one's own
Searching for weaknesses and flaws in the other position	Searching for strengths and value in the other position
Seeking an outcome that agrees with your position	Discovering new possibilities and opportunities

GROUND-RULES FOR DIALOGUE

1. The purpose of dialogue is to understand and to learn from one another (you cannot "win" a dialogue).
2. All dialogue participants speak for themselves, not as representatives of special interests.
3. Treat everyone in a dialogue as an equal: leave role, status and stereotypes at the door.
4. Be open and listen to others even when you disagree, and suspend judgment (try not to rush to judgment).
5. Search for assumptions (especially your own).
6. Listen with empathy to the views of others: acknowledge you have heard the other especially when you disagree.
7. Look for common ground.
8. Express disagreement in terms of ideas, not personality or motives.
9. Keep dialogue and decision-making as separate activities (dialogue should always come before decision-making).
10. All points of view deserve respect and all will be recorded (without attribution).

FOUR SCENARIOS

Scenario 1 — More public investment

Introduction

The first scenario is to add more resources (such as doctors, nurses and equipment) by increasing public spending in order both to deal with Medicare's current problems and to meet future demands (including a growing and aging population and the increasing cost of new technologies and treatments).

People who support this scenario tend to believe that Medicare's problems are due to inadequate public funding. What we need to do is to increase public spending either through tax increases or reallocating funds from other government priorities to improve service and access.

Background

- In the early to mid 1990s, as governments grappled with deficits, rates of growth in health care spending dropped significantly. Overall, public spending on health care, which had been growing at a rate of about 7% each year, stopped growing and even declined briefly.[9]
- Funding began to increase significantly again in the late 1990s, and in 2000 the federal government committed an additional $21.2 billion over five years to health care system renewal.
- In the future, just to maintain the status quo, provincial governments say that health spending will have to grow by 5% per year.[10] In other words, while today health care accounts for about a third (39%) of total provincial and territorial government spending, it will reach 45% of their total spending by the year 2020,[11] perhaps forcing cuts in other important priorities such as education.
- If we decide to improve the system and increase coverage to include things like prescription drugs and home care those costs would increase even more.
- Studies estimate that the health care system (for example, doctors and hospitals) is only one contributor to health outcomes (how healthy people are). Also very important are factors such as socio-economic status (income and education), genes and physical environment.[12]

Survey Results Supporting This Scenario

- Canadians **strongly support the current system** of universal, publicly financed health care: 88% rated it as "very important." [1]*
- While public satisfaction with the health care system has dropped by more than half in the last decade, most Canadians (80%) who actually received health care services in the last year rated the quality of care as excellent or good.
- A majority of Canadians (54%) believe that the government should cover rising health care costs by **significantly increasing spending**. [10]*
- Three-quarters of Canadians (76%) feel that their health care system is facing a **major funding crisis**. [17]*
- Most (86%) feel that the **government should pay for health care for all people** rather than for paying for low income people only or having individuals pay on their own. [2]*
- Nearly 80% believe that **care should be based on need**, not on ability to pay. [8]*
- Four out of five Canadians (82%) feel that Canada's health care system is a **crucial part of the national identity**. [6]*

* References correspond to figure numbers in Mendelsohn, Matthew, "Canadians' Thoughts on Their Health Care System: Preserving the Canadian Model Through Innovation," prepared for the Commission on the Future of Health Care in Canada, Regina, November 2001.

KEY ELEMENTS OF THIS SCENARIO

- The range of services covered by Medicare would remain essentially unchanged, and there would be no fundamental changes in the way that health care services are organized and delivered.
- Increased public spending would be sharply focused on adding resources (such as doctors, nurses, equipment) in order to meet increasing demand and deal with service problems, such as long waiting times and the small number of doctors willing to take on new patients.
- At the very least, an additional $4.2 billion would be necessary by 2005 to meet demand (and, this does not include the costs of new diagnostic and treatment technologies as there is no way to predict these costs).[*13] For example, by 2005,
  - . A low income individual would be paying $85 more in taxes.[**]
  - . A middle income individual would be paying $285 more.
  - . An upper income individual would be paying $630 more.
- To meet increasing demand by the year 2010 would require a further increase of at least $9.5 billion in spending. This would mean that on average personal income taxes would be 12 percent higher than in 1999. By 2010,
  - . A low income individual would be paying $265 more
  - . A middle income individual would be paying $905 more
  - . An upper income individual would be paying $2,000 more
- To avoid the tax increases, the rising cost of Medicare might be met by transferring funds from other government services such as education.

  For example, to avoid the tax increase in 2005, governments would need to reduce education spending by 6%. To avoid the tax

---

[*] Calculations are based on Conference Board of Canada projections of average annual growth of 5.2% due to inflation, real increases in services per capita, population growth and aging.

[**] Low income has been defined as $20,000-$25,000; middle income as $40,000-$50,000; upper income as $70,000-$80,000.

increase in 2010 would require even greater cuts in education or other government services.

PROS:

ARGUMENTS IN FAVOUR OF SCENARIO 1: MORE PUBLIC INVESTMENT

- ✓ If it isn't broken, don't fix it. Medicare is basically sound. Its problems, such as long waiting times, are primarily due to inadequate funding. To reverse recent deterioration we simply need to restore an adequate level of public funding.
- ✓ Public funding is the fairest way to provide the increased resources for health care we need.
- ✓ Our health care system is an essential part of what it means to be Canadian. We must not starve it of the public investment it needs to stop and reverse the deterioration of recent years.
- ✓ We need to face the facts: we need to pay more now and the costs will continue to increase. We should be willing to pay more taxes to provide good quality, reliable health care for all Canadians.
- ✓ When it comes to changing Medicare, we should be very careful. We should make only those changes that are absolutely necessary to preserve it.
- ✓ Drastic changes always have unanticipated consequences. Large-scale changes in the health care system may make things worse rather than better. This scenario allows for gradual improvements as we gain experience.

CONS:

ARGUMENTS AGAINST SCENARIO 1:

MORE PUBLIC INVESTMENT

- We can't afford to keep the current system as it is. Taxes will keep going up and up, or else we'll have to rob money from other important priorities such as education.
- The health care system is only one contributor to health outcomes. It makes no sense to transfer funds from other areas such as education and social assistance that also contribute greatly to good health outcomes.
- Canada is a lot more than its health care system, that's not what defines our national identity. We need to be pragmatic and design a more workable system. We can't afford to have health care eat up more and more of our budget.
- We need to find ways to modernize a system that was designed in the 1960s; we need to introduce efficiencies and innovations.
- The current system provides few incentives to save money. Adding more tax dollars won't solve that; it may even make it worse. We need to reform the system before raising taxes.
- Preserving the current system doesn't go far enough, we also need to add coverage for home care and prescription drugs and other services that are becoming much more important and costly. That will increase taxes even more.

Scenario 2 — Share the costs and responsibilities

Introduction

The second scenario is to add more resources to deal with current problems not by increasing public spending but through a system of user co-payments for health care services that will provide an incentive for people not to over-use the system as well as needed funds.

People who support this scenario tend to believe that we should add more resources to deal with problems, but not rely on public spending to do so. Instead we should share those costs with users — provided that lower income Canadians are fully protected. In this way we can provide an incentive for people not to over-use health services, and ensure that the additional monies paid by Canadians go directly to health care.

Background

- **Just to maintain the status quo, it is predicted that provincial and territorial governments will have to boost their health care spending from 39% of their total program spending today, to 45% of their total program spending by the year 2020.**
- Looked at differently, to preserve the existing level of services, public spending on health care is expected to grow by 58% per person over the next 20 years. The increase will need to be even greater if coverage is expanded to include things like home care and prescription drugs. By comparison, spending on all other government services will increase by 17% per person.[14]
- In Sweden, people pay about $15 when they visit their doctors and about $30 when they consult a specialist. In France, people pay about $30 when they visit their doctors and $40 to see a specialist.[15]

Survey Results Supporting This Scenario

- Most Canadians (81%) predict that the system will be **more expensive to maintain** in the future. [15]*
- Two thirds (66%) believe that **many Canadians misuse the health care system** and that this increases costs. [95]*
- The vast majority of Canadians (87%) rated people's **unnecessary use of services** (for which there is no out-of-pocket fee) as the leading cause of the system's inefficiency. [93]*
- 70% of Canadians say that **those who can afford it should pay more** of their health care costs, only 31% say that the money should come from increased taxes. [54]*
- To increase the health care budget, more than half of Canadians (56%) favour **collecting user fees from those who use the system more** than a certain amount, and 42% support hospital user fees. [74]*

* References correspond to figure numbers in Mendelsohn, Matthew, "Canadians' Thoughts on Their Health Care System: Preserving the Canadian Model Through Innovation," prepared for the Commission on the Future of Health Care in Canada, Regina, November 2001.

KEY ELEMENTS OF THIS SCENARIO

- There would be no increase in tax rates to fund health care. The range of services covered by Medicare would remain unchanged.
- To expand resources in 2005 and in 2010 to deal with current service problems, meet increasing demand, and at the same time discourage over-use of the system, health services would require a co-payment by users.[16]
- The co-payments of lower income Canadians would be subsidized.
- For example, in 2005, each Canadian might pay $30 for doctor visits, $55 to see a specialist and $30/day for hospital stays. In one year the maximum amount that any Canadian would be required to pay for these services would be $500.
- In 2010 (to cover the continually increasing cost of the health care system) patient co-payments might need to be raised to $60 for doctor visits, $120 for specialist consultations and $60/day for hospital stays. In one year the maximum amount that any Canadian would be required to pay for covered services would be $3,000.
- If coverage is added for home care and pharmacare there would need to be further increases in user co-payments.

PROS:

ARGUMENTS IN FAVOUR OF SCENARIO 2:

SHARE THE COSTS AND RESPONSIBILITIES

- ✓ The present system leads to over-use. User payments will do the opposite: they give people an incentive *not* to over-use the system —to think twice before they use it.
- ✓ Those who use the health system extensively should pay more than those who use it very little.
- ✓ This scenario will make it unnecessary to increase our tax burden, which is already high enough. Especially in a globally competitive world we cannot allow our personal tax rates to go any higher.
- ✓ This ensures that additional monies paid by Canadians go directly to health care, and strengthens the sense of accountability that providers feel toward patients who will be paying some of the costs out of pocket.
- ✓ Since lower income Canadians will have their co-payments reduced or eliminated, fairness will be preserved.
- ✓ Other countries in Europe and elsewhere (for example Sweden and France) already have such user co-payments as part of their public health care systems.

CONS:

ARGUMENTS AGAINST SCENARIO 2:

SHARE THE COSTS AND RESPONSIBILITIES

- User payments will discourage people who need health services from seeking them, especially those who feel they cannot afford them. It will discourage early treatment, and we know that early treatment leads to better outcomes and lower health care costs overall.
- There is no clear evidence that over-use of health care services is a major problem.[17]
- Each Canadian will pay twice for health services received — continued high taxes and more out of pocket.
- Most of the spending on health care is beyond a patient's control — visits to specialists, all hospital care and prescription drugs are usually given on a doctor's order.
- The cost of administering a system of patient co-payments can be substantial.
- This scenario puts the burden on patients, it doesn't ask doctors or hospitals or others to share the costs.

Scenario 3 — Increase private choice

Introduction

The third scenario is to give Canadians increased choice in accessing private providers for health care services. Side-by-side with the public system, Canadians also could access health care service from a provincially licensed private sector provider (either for-profit or not-for-profit) and pay for it from their own resources or private insurance.

Those who support this scenario tend to believe that the best way to protect our system of health care, deal with service problems and expand coverage is to encourage greater private sector investment to reduce pressure on the public system and to give Canadians more alternatives and service options.

Background

- As a rule, **Canadians cannot buy private insurance for publicly insured services**. If they visit one of the very few doctors who has opted out of Medicare they must generally pay out of their own pocket.
- **The law says that doctors must choose either to provide services under Medicare, or to opt out** and bill patients privately. They cannot do both but must choose to work either within or outside Medicare. In reality, in a number of provinces doctors working in the public system also provide the same medical services in private clinics where patients pay out of their own pockets. Provinces allow this as a way to reduce pressure on the public system.
- Most doctors work as self-employed individuals. Over 95% of hospitals are private entities; **but most are not-for-profit organizations**. Within hospitals, private contractors provide many services such as laboratories, catering, maintenance and security.
- **In some provinces, private clinics provide medical, surgical and diagnostic services and charge individuals directly**. This is acceptable as long as they do not also bill provincial insurance plans. For example, there are private MRI clinics in British Columbia, Alberta, Ontario and Quebec.[18]
- **In some instances, provincial health authorities purchase procedures and treatments for patients from private clinics** and this is acceptable as long as the clinics do not bill patients extra for those services (extra billing).

Survey Results Supporting This Scenario

- Three out of four (73%) feel that Canadians **should have the option of turning to a private facility** when the public system does not provide timely access to health care services. [64]*
- Nationwide, 15% of Canadians say they have been **unable to obtain health care services** when needed (up from 2% in 1989). [27]*
- Majorities of Canadians fault the system's performance when it comes to **waiting for health care services**: in the emergency room (72%), for specialists (69%), for prescribed surgery (64%), and for non-emergency surgery (61%). [32]*
- 47% of Canadians agree that it is all right if Canada's health care system evolves into a **two-tier system** where both privately owned and public health institutions offer all health services. [58]*
- Canadians feel more **empowered to make health care decisions.** More than two-thirds (69%) ask their doctors questions about medications being prescribed, and nearly three-quarters (72%) say they prefer their doctor to offer them choices among various treatment options. [34]*

* References correspond to figure numbers in Mendelsohn, Matthew, "Canadians' Thoughts on Their Health Care System: Preserving the Canadian Model Through Innovation," prepared for the Commission on the Future of Health Care in Canada, Regina, November 2001.

KEY ELEMENTS OF THIS SCENARIO

- The range of services covered by Medicare would remain unchanged.
- Private clinics (either for-profit or not-for-profit), that are licensed by the provincial government so that they meet the same quality standards as the public system, could provide all health care services and be paid either under Medicare or privately. When they are paid under Medicare, the private clinics would be prohibited from billing patients extra.
- Patients would have the option of receiving health care services either from the public system as at present or privately. When they choose the private option, patients would pay 100% of the cost of health care services they receive. The difference is that instead of having to pay that amount out of their own pocket, they now could choose to purchase private insurance either individually or through group plans (for example, at work).
- Doctors and other health care providers would no longer have to choose either to be part of Medicare or to opt out. Instead they could make that choice along with their patients case by case — choosing in what cases they will work under Medicare and in what cases they will bill privately.
- If coverage is expanded to include pharmacare and home care, this would be done either through an increase in public spending (as in Scenario 1) or through a subsidy to Canadians to help them purchase private insurance.

PROS:

ARGUMENTS IN FAVOUR OF SCENARIO 3:

INCREASE PRIVATE CHOICE

- ✓ This scenario does not change the existing public system of health care. It avoids the increase in public spending in Scenario 1 and the mandatory user fees in Scenario 2.
- ✓ It makes sense to encourage private investment to take pressure off the public system. That investment will be essential to deal with increasing demands in the coming years without huge tax increases.
- ✓ It is important to give Canadians more options in accessing health care. This will result in quicker service, less waiting time, and fewer lost hours at work.
- ✓ Providing private sector alternatives will create competition and incentives to innovate and improve service.
- ✓ Canadians want greater choice to select the health care services of greatest value to them and their families. Private clinics that provide such services already are springing up across the country.
- ✓ Some Canadians already spend their own money to improve their health care by going to the U.S. for services. All Canadians should be able to do this without leaving the country.

CONS:

ARGUMENTS AGAINST SCENARIO 3:

INCREASE PRIVATE CHOICE

- This creates a two-tier system of health care nationally. It accepts the idea that those with more money should be able to jump the queue and get faster or better service.
- The real effect will be to diminish the quality of service to Canadians who do not have additional private insurance. The poor will be at a disadvantage; they don't have the resources to pay premiums for additional private health insurance coverage. Over time, to reduce costs, governments will cut back the services available publicly, forcing people to pay privately for those health care services or to go without.
- Costs will increase overall. Some Canadians will be paying twice for health care services, first through taxes and then through private insurance or out-of-pocket payments.
- The private sector providers will accept healthier patients who can pay but will turn away those who are high risk. The public system will be left to deal with those who are poorest and most ill.
- This scenario will help those with money to obtain a health care service more quickly, whether they need it or not.
- If they don't have to opt out of Medicare entirely in order to work in private clinics, the best medical professionals will be attracted to put more of their time into the private clinics, diminishing the quality of service in public hospitals and health care facilities.

Scenario 4 — Reorganize service delivery

Introduction

The fourth scenario is to reorganize service delivery in order to provide more integrated care, realize efficiencies and expand coverage. Under this scenario, each Canadian would sign up with a Health Care Provider Network who would work as a team to provide more coordinated, cost-effective services and improved access to care.

Those who support this scenario tend to believe that adding resources to our health care system indefinitely — whether through increased public spending, user fees or private investment — is not responsible nor sustainable. The long-term solution is to reorganize the delivery of health care services to remove incentives that now encourage fragmented treatment, waste and misuse, and replace those with incentives that encourage coordination, efficiency and improve the quality of care.

Background

- Medicare pays doctors' fees but rarely does it pay those of other professionals. Since Medicare won't pay for the services of others, there is an incentive to use the relatively expensive services of a physician even when a less costly professional might be able to provide the service.
- Doctors are usually paid on a "fee-for-service" basis, which means they get paid a prescribed amount for a particular procedure or service, no matter how much time they spend. This arrangement provides an incentive for doctors to operate on their own, pay less attention to coordinating care with other professionals, adopt a procedure-by-procedure perspective, speed up visits and schedule multiple visits, provide services that take very little of their time and stop providing services that require more time.
- A majority of physicians (6 out of 10 in a survey by the Canadian Medical Association) would prefer a different system of compensation — either a salary or a blending of salary and fee for service.
- Nine out of ten of the people who arrive at hospital emergency rooms don't really require emergency care.[19]
- Across Canada there are a number of health care reform initiatives underway; pharmacists with special training are working more closely with physicians, multi-disciplinary group practices are being organized, various new approaches to paying professionals are being adopted. In a number of provinces, telephone advice lines have been implemented successfully and have reduced pressures on hospital emergency rooms.[20]

Survey Results Supporting This Scenario

- Three out of four in Ontario (76%) feel that **money alone will not solve the problem** of securing health care for the future. [12]*
- Nearly three-quarters of Canadians (74%) would **prefer to see a family doctor who works as part of a team** rather than one who practices on his or her own. [83]*
- Almost half the residents in Saskatchewan (49%) think that Primary Health Service Teams would **improve the quality of care** they receive. [81]*
- For routine health care services, a majority of Canadians (54%) say they would be **satisfied to see a specialized nurse** rather than a doctor (an additional 25% had no strong objections). [82]*
- A majority of Canadians (51%) would put more emphasis on investing in new approaches like **community care and early prevention** than on investing more in the current system. [85]*

* References correspond to figure numbers in Mendelsohn, Matthew, "Canadians' Thoughts on Their Health Care System: Preserving the Canadian Model Through Innovation," prepared for the Commission on the Future of Health Care in Canada, Regina, November 2001.

KEY ELEMENTS OF THIS SCENARIO:

- Each family and individual would enroll with a multidisciplinary Health Care Provider Network (including doctors, nurses, nutritionists, pharmacists, psychologists and other providers) who would work together as a team to provide integrated care in the most cost-effective way. The Network would provide primary care and connect their patients to any additional care required, including hospitals, home care, palliative care, prescription drugs and other services.
- Individuals and families would receive their health care services through that Network, and could change their enrollment only once a year or when they move out of the area.
- Each Network would provide or be affiliated with a clinic that is open 24 hours a day, 7 days a week, and provides both walk-in service for registered patients and telephone advice.
- In rural areas Networks would need to cover larger geographic areas and there may be only one Network in each area. In addition, special arrangements would be made to ensure comparable levels of service.
- Medicare would pay each Network a negotiated amount of money each year for each individual or family they have enrolled to provide primary care and to purchase any additional services required from hospitals and specialists. Additional funds would be provided for special needs populations (e.g., those who require dialysis).
- Because each Network would receive a fixed amount of funds from Medicare each year per person enrolled, there would be an incentive to provide service in the most cost effective way. For example, a patient would not see a doctor when a nurse or other professional could provide the needed care. The Networks also would have an incentive to emphasize prevention and to provide patients with information and education that would allow them to assume more responsibility for their own care.
- The reorganization would be designed to integrate and improve service, expand coverage (to include home care and pharmacare), and provide efficiency gains that would reduce the increase in public spending required (compared to Scenario 1).

PROS:

ARGUMENTS IN FAVOUR OF SCENARIO 4: REORGANIZE SERVICE DELIVERY

- ✓ The new Provider Networks will provide one-stop-shopping — patients and their families will have better and faster access to a wider range of health care providers and services, which now also will include home care, palliative care, prescription drugs and more.
- ✓ By working together as a team, providers can offer more coordinated, seamless and efficient care, reducing unnecessary services or patient visits, avoiding conflicting prescriptions, and treating the "whole person".
- ✓ Patients will receive access to a clinic and telephone advice available 24/7, increasing the level of service while reducing unnecessary demands on hospital emergency rooms.
- ✓ Because of their fixed per-capita level of funding, Provider Networks have a strong incentive to encourage prevention and provide the most cost-effective care.
- ✓ Physicians and other providers in a Network will have more predictable hours and income, and a much greater ability to share the heavy demands of patient care and running a practice.
- ✓ By changing incentives and organizing health care services more efficiently we can keep health care costs from spiraling out of control. This is a much more sustainable approach. We can provide better service and increased coverage while limiting the escalating need for more taxes, user fees or private sector investment.

CONS:

ARGUMENTS AGAINST SCENARIO 4:

REORGANIZE SERVICE DELIVERY

- By confining people to the Provider Network with which they are enrolled (and can change only once a year or when they move out of an area), Canadians will be directed into Networks that can easily become bureaucratic, rigid and unresponsive.
- The link between a patient and his or her primary care physician is very important, and that will be weakened or destroyed.
- When the Network insists that you see someone who is not a physician, it may be taking an unwarranted risk with your health in order to save money. However good the intentions may be, quality of care will inevitably be sacrificed to an impersonal system concerned above all with cutting costs rather than with quality of care.
- It will be much more difficult to get a real second opinion when you want and need one.
- We are asking people to change the way they seek health care, and there is bound to be stiff resistance. We are also asking physicians and other health care providers to dramatically change the way they work. That's a lot to ask and morale is bound to suffer.
- The transition to this new organization of primary health care will be complicated and costly, and there may not be significant savings even in the longer term.

Notes

1 Porteous, Wendy F., Citizens' Forum on Canada's Future: Report on the Consultative Process, (Canadian Centre for Management Development, Ottawa, March 1992); Ham, Laurie, Strengthening Government-Citizen Connections: Health Policy in Canada (OECD, Paris, 2000).

2 Abelson, Julia, Jonathan Lomas, John Eyles, Stephen Birch, and Gerry Veenstra, "Does the Community Want Devolved Authority? Results of Deliberative Polling in Ontario," Canadian Medical Association Journal, August 15, 1995; Abelson, Julia and Jonathan Lomas, "In Search of Informed Input: A Systematic Approach to Involving the Public in Community Decision-Making," Healthcare Management Forum, Winter, 1996; Forest, Pierre-Gerlier, Julia Abelson, François-Pierre Gauvin, Patricia Smith, Elisabeth Martin, et John Eyles, "Participation de la population et décision dans le système de santé et de services sociaux du Québec," étude réalisée à la requête du Conseil de la santé et du bien-être du Québec, Quebec, 2000.

3 The description of Viewpoint Learning, Inc.'s ChoiceWork methodology provided in this section is protected by copyright.

4 Yankelovich, Daniel, *The Magic of Dialogue: Transforming Conflict into Cooperation* (New York, N.Y.: Simon & Schuster, Inc., 2001); and *Coming to Public Judgment: Making Democracy Work in a Complex World* (Syracuse, N.Y.: Syracuse University Press, 1991).

5 See Appendix 1 for more detail on the ChoiceWork Dialogue methodology.

6 See Appendix 2 for Dialogue dates and places.

7 Medicare is defined as all *Canada Health Act* services plus others publicly financed and provided by provincial health insurance plans.

8 Amounts expressed in 1992 constant dollars. The principal source of spending data in the workbook is the Conference Board of Canada's study "The Future Cost of Health Care in Canada, 2000 to 2020: Balancing Affordability and Sustainability." It was the only public data source found that would permit citizens to be provided with national spending forecasts out to 2020. The Conference Board forecasts are based upon inflation, population growth, aging, and real increases in the volume of services. In its study, the Conference Board excluded expenditures by municipal governments, workers' compensation boards and federal government direct spending.

9 This bullet does not appear in the workbook. Facilitators explained it verbally using the wall chart.

10 While recognized as extremely controversial, the research team considered it important that citizens be provided information that would give them some sense of the split between federal and provincial funding. As a result they were provided with the 65-35 split with an explanatory footnote. That footnote explained that "*The federal share of 35% includes some tax points (ie. power to tax) transferred to the provinces in 1977. If the tax points are not included, then the federal share is about 18% and the provincial share is 82%*" (Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians – The Federal Role (Interim Report – Volume One, The Story So Far)*, March 2001, p. 23-24, www.parl.gc.ca).

11 Two other scenarios were seriously considered and rejected by the project team. One would have been built around the issue of coverage – both the de-listing of some current services and the expansion to include others not now covered. The project team decided against this scenario as citizens are not best placed to determine what is "medically necessary," and instead expanded coverage was treated as a cross-cutting issue in the four scenarios. A second possible scenario would have been greater private delivery with a single risk pool retained and no expansion o f private payment either out-of-pocket or

through private insurance coverage. This one proved insufficiently robust to describe something significantly different from the status quo and the project team chose to push citizens to their limits on privatization.

12 An important qualifier needs to be mentioned here. Despite an extensive search of both Canadian and international sources, the project team was unable to identify credible sources to provide citizens with information on the potential implementation costs and the potential savings over the longer term associated with primary care reform. One possible source was a technical costing report "Proposed Inter-professional Primary Health Care Groups (PCGs) Costing Models," prepared by Milliman & Robertson Inc. for the Health Services Restructuring Commission's Primary Health Care Strategy in Ontario in 1999. The project team had no way to verify the findings.

13 National Forum on Health, *Canada Health Action: Building the Legacy*, Volume II, Synthesis Reports and Issues Papers, 1997, p. 4, at www.nfh.hc-sc.gc.ca.

14 Ibid., Volume II, p. 3 to 38.

15 "The majority of participants were ingenious at avoiding the hard choices. They see our health system as threatened but are loath to trade off the current system against the promise of better or fairer future performance. Many see 'health reform' as a code for withdrawal of services" (National Forum on Health, *Canada Health Action: Building the Legacy*, Volume II, Synthesis Reports and Issues Papers, 1997, p. 8, at www.nfh.hc-sc.gc.ca*)*.

16 The telephone survey involved a random sample of 1,600 Canadians. It took place between March 14 and 21, 2002. Once the data collection was completed, the results were statistically weighted by age, gender and region to ensure that the findings were representative of the Canadian population aged 18 and over. This sample size is considered statistically accurate within +/- 2.5 percentage points, 19 times out of 20.

17 Indeed, when the telephone poll asked respondents to choose which one of the four scenarios would be their first preference, public investment was chosen most frequently (42 percent) compared to primary care reform (25 percent), user fees (22 percent) and access to private health services (9 percent). However, to these respondents, public investment meant reallocating expenditures, not raising taxes.

18 The 4-point scale encourages the respondent to be either for or against the scenario in question, minimizing the number of "undecided" votes – people who say that they don't know or have no opinion. The 7-point scale permits people to select a score right in the centre of the scale, maximizing the number of those who remain on the fence. They are not truly undecided; they are simply ambivalent. (To illustrate this technical point, if you were to apportion those who gave a score of "4" in the dialogues to both the support and oppose columns, the results move in the direction of the poll numbers). The 4-point scale used in the survey was strongly support, somewhat support, somewhat oppose, strongly oppose. The 7-point scale in the dialogue questionnaires was defined as "a scale of 1 to 7 (1=totally unfavourable, 7=totally favourable – please circle one number for each choice)."

19 Quote from the Commissioner's letter to the Dialogue participants included in the workbook.

20 Canadian Policy Research Networks, *Indicators of Quality of Life in Canada: A Citizens' Prototype*, Summary of Results of Public Dialogue Sessions and Prototype of National Indicators, Ottawa, April 2001.

Workbook Notes

1 Conference Board of Canada, The Future Cost of Health Care in Canada, 2000 to 2020: Balancing Affordability and Sustainability, Ottawa, Fall 2001.

2 Mendelson, Matthew, Canadians' Thoughts on Their Health Care System: Preserving the Canadian Model Through Innovation, prepared for the Royal Commission on the Future of Health Care in Canada, Saskatoon, November 2001, (see Figure 3 from Ipsos-Reid).

3 Ibid., see Figure 30 from Commonwealth Fund 1998 International Health Policy Survey; Figure 31 from Ipsos-Reid, 2000; and Figure 32 from Earnscliffe/POLLARA, 1998.

4 Health Canada, "Profile of Home Care Statistics in Canada – Number of Home Care Clients Served by Type of Service (1996-97) – Data provided by Provinces/Territories," at www.hc-sc.gc.ca/homecare/english/stat_7.html.

5 Mendelsohn, op. cit., see Figure 7 from Environics Focus Canada Surveys and Figure 8 from Earnscliffe/POLLARA, 1998.

6 Canadian Institute for Health Information (CIHI), Health Care in Canada, Ottawa, p. 71-73; Standing Senate Committee on Social Affairs, Science and Technology, The Health of Canadians – The Federal Role (Interim Report – Volume One, The Story So Far), Ottawa, March 2001, p. 23-24.

7 Evans, R. G., "Canada," special section of Journal of Health Politics, Policy and Law 25 (5), October 2000, at www.jhppl.org.

8 CIHI, op. cit., p. 72-73.

9 Conference Board of Canada, op. cit., Appendices.

10 Provincial and Territorial Ministers of Health, Understanding Canada's Health Care Costs, Final Report, August 2000, p. 30-31 (www.gov.on.ca/health/english/pub).

11 Conference Board of Canada, Performance and Potential 2001-2002, Ottawa, 2001.

12 Standing Senate Committee, op. cit., p. 81.

13 The Conference Board forecasts that public health spending needs to increase by 5.2% on average each year from 2000 through to 2020 to respond to population growth, aging, real increases in the volume of services and inflation. At the same time, provincial and territorial revenues, including federal transfers, are projected to increase by 3.6% per year on average through to 2020. The added requirement for health spending could be filled by allowing the share of public health care spending to grow at the expense of other expenditures. Alternatively taxes could be increased. In 2001, the Conference Board estimates that public spending on health of $66 billion stands at 32.6% of total provincial and territorial revenues. At a minimum, to respond to the factors identified above, the Conference Board projects that public health care costs must grow to $78.6 billion in 2005, consuming 34.4% of total revenues if tax rates are maintained at current levels. To hold health care spending at 32.6% of total projected revenues in 2005 would make available $74.4 billion, representing a shortfall of $4.2 billion. In 2010, the Conference Board estimates public health care spending requirements of $101.5 billion. With total projected revenue of $282.1 billion (adding in the tax increase effects from 2005), 32.6% would be $92.0 billion, leaving a shortfall of $9.5 billion.

---

14 Conference Board of Canada, The Future Cost of Health Care, op. cit.

15 Swedish National Board of Health and Welfare, Patient Charges and Demand for Care, 2000, at www.sos.se/sos/publ/REFERNG/0003008E.htm. For France, Physicians for a National Health Program, "International Health Systems," undated, cited on-line at pnhp.org/international.htm.

16 The amounts being raised through the co-payment examples are $4.2 billion in 2005 and $11.2 billion in 2010 plus an estimated 15% for administrative costs. The net amounts are equivalent to the amounts raised through the tax increases (with compounding) in Scenario 1. No change in behaviour was assumed. It was assumed that visits to doctors and to specialists would increase by 0.7% per annum based upon historical trends. Hospital patient days per capita were estimated to be 0.69 days in both 2005 and 2010. Distribution of health care usage was extrapolated from insured drug and supplementary hospital benefits distribution. The distribution shifts only with inflation over the years.

17 Stoddart, G. L., M. L. Barer and R. G. Evans, "User Charges, Snares and Delusions: Another Look at the Literature." Ontario Premier's Council on Health, Well-being and Social Justice Discussion Paper, Toronto, 1994.

18 "Canada's medical system lacks many bells and whistles," State of Health Care Quarterly Report, National Post, November 2001.

19 Rachlis, M., Revitalizing Medicare: Shared Problems, Public Solutions. Tommy Douglas Research Institute, Vancouver, 2001.

20 Saskatchewan Commission on Medicare, Caring for Medicare, Sustaining a Quality System, Regina, April 2001, p. 98.